



MEDICAL AESTHETICS & WELLNESS

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Today's Date:

Patient name:

Date of Birth:

Address:

City:

State:

Zip:

Phone:

Email:

Emergency contact:

Relationship:

Phone:

How did you hear about us? ☐ Friend ☐ Physician referral ☐ Internet search ☐ Billboard

☐ Other:

(If you were referred by a friend or physician, please write their name on the line)

GENERAL HEALTH INFORMATION

Primary care provider:

Date of last physical:

Are you in good health? ☐ Yes ☐ No:

Known drug allergies? ☐ No ☐ Yes (please list medication(s) and type of reaction):

Current medications (prescription, OTC, vitamins, and supplements)

Frequent use (>1x/week) of aspirin, Advil, Motrin, ibuprofen, or other anti-inflammatory medications?

☐ No ☐ Yes:

Smoking? ☐ No ☐ Yes, frequency:

Former smoker? ☐ No ☐ Yes

Alcohol? ☐ No ☐ Yes, frequency:

Recreational drugs? ☐ No ☐ Yes, type/frequency:

Tanning beds? ☐ No ☐ Yes, type/frequency:

Pregnant? ☐ No ☐ Yes

Trying to become pregnant? ☐ No ☐ Yes

Breastfeeding? ☐ No ☐ Yes

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MEDICAL HISTORY

Please check all that apply

- | | | |
|---|---|---|
| ☐ Anemia | ☐ Excessive bleeding | ☐ Low blood pressure |
| ☐ Anxiety | ☐ Excessive scarring/keloids | ☐ Lung disease |
| ☐ Arthritis | ☐ Facial Trauma | ☐ Liver disease |
| ☐ Asthma | ☐ Heart attack | ☐ Migraines |
| ☐ Autoimmune disorder: | ☐ Heart failure | ☐ Migraines with aura |
| | ☐ Heart valve disease | ☐ Multiple sclerosis |
| ☐ Blood disorder | ☐ Heart valve replacement | ☐ Muscular dystrophy |
| ☐ Bruise easily | ☐ Hepatitis | ☐ MVP |
| ☐ Cancer: | ☐ High blood pressure | ☐ Rheumatic fever |
| | ☐ High cholesterol | ☐ Seizures |
| ☐ Chest pain | ☐ HIV | ☐ Shortness of breath |
| ☐ Chronic diarrhea | ☐ Intestinal problems | ☐ Stomach problems |
| ☐ Clotting disorder | ☐ Irregular heart beat | ☐ Stroke |
| ☐ Colon problems | ☐ Irregular mole | ☐ Tattoos or permanent makeup |
| ☐ Diabetes | ☐ Kidney disease | ☐ Varicose veins |
| ☐ Depression | | ☐ Vasovagal syncope (fainting) |

Please list all surgeries including cosmetic:

_____	Date: _____
_____	Date: _____
_____	Date: _____

Skin conditions:

- | | | |
|--|--|--|
| ☐ Rosacea | ☐ Acne | ☐ Post-inflammatory hyperpigmentation (PIH) |
| Diagnosed by: | ☐ Actinic Keratosis | ☐ Sebaceous hyperplasia |
| ☐ Self ☐ Physician | ☐ Cold sores (HSV) | ☐ Seborrheic dermatitis |
| ☐ Melasma | ☐ Eczema / Dermatitis | ☐ Skin cancer |
| Diagnosed by: | ☐ Psoriasis | ☐ Vitiligo |
| ☐ Self ☐ Physician | ☐ Perioral dermatitis | |

☐ Other: _____

SKIN HEALTH

Skin type: ☐ Oily ☐ Dry ☐ Combination ☐ Sensitive ☐ Normal

Skin sensitivity: ☐ Burns easily ☐ Reacts to products ☐ No sensitivities

Daily sunscreen use? ☐ Yes ☐ No

Recent sun exposure or tanning within the last 4 weeks? ☐ Yes ☐ No

Products or ingredients that irritate your skin:

Additional concerns:

AESTHETIC HISTORY

Please check all that apply and indicate most recent treatment date

☐ Dermal fillers

☐ Laser/IPL/BBL

☐ Sculptra

☐ Chemical peels

☐ Kybella

☐ Microneedling

☐ Threads

☐ PRP/PRF

☐ Sclerotherapy

☐ Facials

☐ Neurotoxins (Botox, Dysport, etc.)

☐ Microneedling with radiofrequency

☐ Body contouring or fat reduction (Coolsculpting, Emsculpting)

☐ Other

Current skincare routine:

Morning:

Evening:

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TREATMENT INTERESTS

- | | |
|--|--|
| ☐ Neuromodulators (Botox, Dysport, Daxxify, etc.) | ☐ Acne treatments |
| ☐ Dermal fillers | ☐ Sclerotherapy |
| ☐ Microneedling | ☐ Laser services (Moxi, Halo, BBL, Sylfirm) |
| ☐ PRX Perfexion | ☐ Facials |
| ☐ Vitamin injections | ☐ Hormone Replacement Therapy (HRT) |
| ☐ Medical weight loss | ☐ Skincare products |

COMMUNICATION PREFERENCES

Okay to leave a voicemail? ☐ Yes ☐ No

Please email me:

- ☐ Appointment reminders
- ☐ Medical information
- ☐ Scheduling
- ☐ Special offers and invitations

Please text me:

- ☐ Appointment reminders
- ☐ Medical information
- ☐ Scheduling
- ☐ Special offers and invitations

CONSENT

I certify that the above information is accurate and I will notify the practice of any changes.

Patient signature:

Provider signature:
