Aesthetic Cosmetic Patient Information Intake History

Name_______________________________________ Date_________________________

Address______________________________________ Date Of Birth__________________

City______________________ State______________ Home Phone___________________

Zip Code____________________ Work Phone___________________

Referred By _____________________________________

Have you undergone treatment from a dermatologist before? Yes_____ No_____

If yes for what condition?

___

___

Reason for today's visit

___

Have you been under a physician's or other health care provider's care in the past year?

Yes_____ No_____

If yes the reason:____

Physician's Name____

Address____

Phone____

Have you had any surgery in the past nine months? Yes_____ No_____

Describe:____

Have you ever had nasal surgery? Yes___ No___ Eye Surgery? Yes_____ No_____

Are you currently using Retin-A, Renova or Differin? Yes____ No____ Strength _____

For how long? ___________ How frequently? _______ Where Applied?______________

DISCONTINUE USE 5 DAYS BEFORE TREATMENT

Do you have regular: Collagen Injections? Yes____ No____

Botox Injections? Yes___ No___

When was your last injection? ___/___/___

Have you ever had a chemical peel or microdermabrasion? Yes ____ No____

Within Last 14 days Yes ____ No ____

What kind?____

Describe your reaction:____

Have you ever had laser resurfacing or dermabrasion? Yes____ No____ When?_______

List all medications you take regularly and reason for taking:
____

____

List all drug allergies:____

Are you allergic/sensitive to: (**Y or N**) Milk___ Apples___ Citrus___ Grapes___ Aloe Vera___ Aspirin___ Perfumes___ Hydroquinone___Other:________________________

List all other allergies:

____

List all vitamins you take on a regular basis:
____

Are you sensitive to alcohol based products? Yes___ No___ Skin lighteners? Yes___ No___

Have you ever used skin care products that caused a skin reaction? Yes___ No___

Describe:

____

Circle any of the following health problems you have had in the past or currently have:

Allergies	Heart Problems	Hysterectomy	Sinus Problems	Shingles
Asthma	Herpes	Cancer	Epilepsy	Rosacea
Eczema	High/low Blood Pressure	Thyroid Problems	Diabetes	Psoriasis
	Hormone Imbalance	Varicose Veins	HIV	

Is there a family history of skin cancer? Yes ____ No ____

Do you have any open sores or abrasions? Yes ____ No ____

Do you have any implants (pacemaker, pins in bones, etc")? Yes ____ No ____
Explain:____

Have you ever had cold sores/fever blisters? Yes ____ No ____ Last break out?
Where?_______ Always same general locations? Yes ____ No ____

Hives? Yes ____ No____ Where?___________ Do you know the cause? If so why?______________________________________

Do you wear contact lenses? Yes ____ No ____ Glasses? Yes ____ No ____
Sunglasses? Yes ____ No ____

Do you currently have a sunburn/wind burn/red face? Yes ____ No______
Why?____

Do you currently get? Facials _____ Waxing _____Electrolysis _____ Depilatories _____

What are you currently using to cleanse your face?______________________________

What are you currently using to moisturize your face?_____________________________

Any special treatments? (eye cream, night cream, masks, scrubs)___________________

What temperature of water do you use to cleanse with? Cool ___ Warm ___ Hot ___

Do you use sunscreen/sun block daily? Yes ___ SPF ___ No ___

Do you sunbathe? Yes ___ No ___ How many hours at a time?____________________

Are you in the habit of going to tanning booths? Yes ___ No ___ How often?__________

Do you wear make-up? Every Day ___ Special Occasions ___ No ___

Are you currently using Biore / Snore strips? Yes ___ No ___

Are you using glycolic / AHA home care products? Yes ___ No ___ When?___________

What type of work do you do?____

Air travel? Yes ___ No ___ How often?_______________________________________

Are you exposed to workplace pollution? Poor ventilation_______, Electrical fields from computers, etc.__________ Secondary smoke?_________________

[STAFF USE] Client review with products present for ingredient review:______________

How does your skin react to them?____

Notes:____

____

____

What Improvements would you like to see concerning your skin?

On Face?____

On Body?____

FEMALE CLIENTS ONLY

Are you currently taking oral contraceptives? Yes ___ No ___

Are you pregnant? Yes ___ No ___

Trying to become pregnant? Yes ___ No ___

Are you breast feeding? Yes ___ No ___

Is your menstrual period due within the next week? Yes ___ No ___

Are your menstrual periods regular? Yes ___ No ___

I confirm, to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client Signature ____

Date_____________________

Client Informed Consent
Cosmetic Procedure Treatment

Patient: You have the right to be informed about this treatment, so that you may make the decision whether or not to undergo the procedure after knowing any risks or hazards involved. This disclosure is not meant to alarm you in any way, it is simply an effort to make you better informed so you may give, or withhold you consent for treatment.

A. I voluntarily request that Louise Diehl APN, and such associates/assistants or any other professional deemed necessary treat me and my condition. I acknowledge having been informed that this procedure is intended to remove fine surface skin in order to improve the vitality and smoothness of the skin.

B. I understand that my provider of treatment can discover other and different conditions which may require additional or different treatments than those planned. I authorize them to perform other procedures which may be advisable in their professional judgment.

C. I realize that while the goal of this treatment is the removal of damaged skin, the results average between 40-85% improvement.

D. I realize that some risks, irritations or hazards could occur from this treatment. I waive all rights to damages incurred from this treatment.

E. I have been made aware of alternative methods available for my treatment, which includes acid peels or laser skin resurfacing.

F. I accept and acknowledge my responsibility to follow the written and or spoken instructions of my provider and to visit them in 7 -10 days post treatment.

G. I understand that multiple treatments are required. The cost of treatments were discussed with me before the initial treatment.

H. I have received a complete explanation of my pre-treatment and post-treatment instructions. I understand the instructions and should I have additional questions I will not hesitate to call.

I certify that I have read and understand the above authorization form. I have been given the opportunity to discuss all my questions, and I have received satisfactory answers. I understand that this procedure uses Aluminum Oxide which is an abrasive therefore I will follow the explicit instructions of my provider.

I have not received any alcohol or medication before signing this consent.

I hereby consent to the Cosmetic procedure or procedures. This document supersedes any previous verbal or written disclosure.

________________________________ ________________________

Patient Pre- Treatment Signature **Witness Signature**

Date: ________________________

Medical History Questionnaire:

Please place an (X) in the yes or no box and explain if you have a yes answer.

1. Have you ever had any allergic reaction, or know of any allergies? YES( ) NO ( )
   If yes please explain below.
   Explain:____

2. Have you been told you are currently pregnant, or think you may be? YES( ) NO ( )
   If yes please explain below.
   Explain:____

3. Have you been told you have diabetes? YES( ) NO ( )
   If yes please explain below.
   Explain:____

4. Have you had shingles, herpes, or cold sore infection? YES( ) NO ( )
   If yes please explain below.
   Explain:____

5. Are you currently using sun block? YES( ) NO ( )
   If yes please explain below.
   Explain:____

6. Have you been told you have skin cancer, or have you ever been told you have a skin condition that concerns your doctor? YES( ) NO ( )
   If yes please explain below.
   Explain:____

7. Have you had any facial reconstructive procedures? YES( ) NO ( )

8. Are you currently using Rentin-A, or Glycolic Skin Care Products? YES( ) NO ( )

9. Have you taken Accutane? YES( ) NO ( )

   If so, Please indicate when you last took Accutane.____________________________

What is your skin care concern:

____

____

Signature:___________________________________ **Date:** _________________________

STAFF USE BELOW:
History reviewed by: Initials_______Date_______;Initials_______Date_________;
Initials_______Date_______;Initials ______ Date_________; Initials ______Date______

Initials ______ Date_______;Initials______Date______; Initials ______Date______