Medical Intake Form

Name:____ Birth Date:_______________

Address: ____

City:______________________________________ State:__________ Zip:____________

Cell Phone:____________________________ Work Phone:________________________

E-Mail:____

Emergency Contact: (Name & Phone)____

Primary Physician: ____

Do we have permission to contact you by phone? _____Yes _____No

Do we have permission to show your non-identifying photos for educational purposes?
_____Yes _____No

Concerns

What concerns you most about the overall appearance of your skin? (check all that apply)

___Acne ___Acne Scarring ___Age Spots

___Blackheads ___ Body Acne ___Broken Blood Vessels

___Bumps on back of arms ___Cysts/Nodules ___Dehydrated Skin

___Dull Complexion ___Excessive Facial Hair ___Facial Veins

___Fine Lines/Wrinkles ___Frequent Breakouts ___Large Pores

___Melasma ___Oily Skin ___Redness

___Rosacea ___Rough/Uneven Skin Texture ___Sun Damage

___Other:____

How would you describe your skin?

___Oily ___Dry ___Combination ___Sensitive

History

Are you currently under the care of a physician? ___Yes ___No Explain:__________

____

Do you have any allergies to foods or medications? ___Yes ___No Explain:____

____

Are you currently on any medications either topical or oral? ___Yes ___No If yes, please list:____

____

Do you smoke? ___Yes ___No

Are you prone to cold sores? ___Yes ___No If yes, date of last cold sore? ______

Do you have an allergy to Latex? ___Yes ___No

Do you tan in the sun or in tanning beds/booths? ___Yes ___No

Please check the skincare products you are currently using:

___Cleanser ___Toner ___Serum ___Scrub ___Mask ___Eye Cream

___Moisturizer ___Sunscreen ___Self Tanner ___Concealer ___Makeup

___Other_____________________

The answers I have provided are true and correct to the best of my knowledge.

______________________________ ______________________________

Client Signature Date

______________________________ ______________________________

Provider Signature Date