

Date \_\_\_\_\_

Name \_\_\_\_\_ Gender M F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact\* Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

(Preferred) Work phone \_\_\_\_\_ E-mail \_\_\_\_\_

\*This information will not be shared with any third party without your permission. We may attempt to contact you at any of the numbers/addresses you provide. While we always try to be as discreet as possible, please do not provide numbers at which you do not wish to be contacted.

**Please circle the items below that apply to you:**

**Hair Removal (last 6 weeks):** plucking waxing depilatories electrolysis

**Tanning (last 6 weeks):** sun exposure tanning bed tanning products

**Medications:** Retin-A (last 3 weeks) Accutane (last 6 months)

**Sensitivity to:** hydroquinone (bleaching agents) glycolic acid (skin cleansers)  
lidocaine (anesthetics) other \_\_\_\_\_

**Skin Conditions:** skin infection herpes (cold sores) keloids / excessive scarring tattoos / permanent make up  
skin cancer poor healing / diabetes easy bruising or bleeding eczema sun sensitivity

**Previous Procedures:** laser/light treatments microdermabrasion chemical peels  
other \_\_\_\_\_

**Medical History:** Pregnant? Y N Maybe N/A  
Any current illness, disease, or condition? Y N  
Current medications (include aspirin, hormones, and contraceptives):  
\_\_\_\_\_  
Allergies (include aspirin) \_\_\_\_\_

**Skin Concerns:** Hair Wrinkles Spider Veins Skin Flushing (redness) Acne  
Texture (pores / pits, scarring, aging) Coloration (dark, age or sun spots)  
Other: \_\_\_\_\_

**Areas of Interest:** Hair removal Skin Renewal Microdermabrasion Acne Treatments Skin Care Products

How did you hear about our clinic? \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_

Technician's Notes: \_\_\_\_\_