Medical Aesthetics & Laser

Patient Intake Form
Client Information and Medical History

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____

Preferred Contact: □ Home □ Cell □ Email **Other:** _____

Would you like to be on our e-mail list to receive appointment reminders and info on product/service specials? □ Yes □ No **E-mail Address:** _____

How did you hear about Medical Aesthetics and Laser? _____

Emergency Contact Name: _____

Relationship: _____ **Phone Number:** _____

WHAT CONDITIONS WOULD YOU LIKE TO IMPROVE ABOUT YOUR SKIN? PLEASE CHECK ALL THAT APPLY:

□ Acne	□ Uneven Tone/Texture	□ Fine Lines/Wrinkles
□ Rosacea	□ Enlarged Pores	□ Sun Damage
□ Facial Scarring	□ Age Spots/Freckles	□ Dehydration

Other Concerns: _____

Are you currently having skin treatments? □ Yes □ No

If yes what type? _____

HEALTH HISTORY:

What type of work do you do? _____

What is your genetic background? _____
Example: German, Hispanic, Indian, French, etc.…

Have you seen a dermatologist in the past year? □ Yes □ No

If yes, please list reason for visit: _____

Are you currently taking medications or supplements? □Yes □ No

If yes, please list: _____

How is your general health? (check one) □ Excellent □ Good □ Fair □ Poor

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FEMALE ONLY – Are you currently: □ Nursing □ Pregnant □ Planning to become pregnant

# of pregnancies _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE EXPERIENCED:

□ Cancer (Chemo/Radiation)	□ HIV/AIDS	□ Keloid scaring	□ Seizure disorder	□ Lupus
□ Circulatory problems	□ Hepatitis	□ Skin Disease	□ Hormone imbalance	□ Hirsutism
□ Implantable devices	□ Fainting	□ Skin lesions	□ Thyroid imbalance	□ Arthritis
□ High blood pressure	□ Eczema	□ Psoriasis	□ Any active infection	□ Cold sores
□ Low blood pressure	□ Dizziness	□ Cystic acne	□ Diabetes	□ Herpes

Any additional health problems or medical conditions? Please list:

_____

ALLERGIES: Please list any known allergies _____
Have you ever had any allergic reactions to the following? Please check all that apply:

□ Aspirin	□ Salicylates	□ Milk	□ Apples	□ Citrus
□ Grapes	□ Fish	□ Latex	□ Iodine	

HOMECARE:

What skincare products, if any are you using at home?

□ Cleanser	□ Exfoliants	□ SPF
□ Toner	□ Moisturizer	□ RX/Specialty

PLEASE MARK IF YOU ARE PRESENTLY USING, OR HAVE EVER USED, ANY OF THE FOLLOWING:

□ Benzoyl Peroxide	□ Glycolic Acid (AHA)	□ Lactic Acid (LHA)	□ Salicylic Acid (BHA)
□ Vitamin A	□ Vitamin C	□ Hydrocortisone (HC)	□ Hydroquinone (HQ)
□ Retin-A	□ Accutane	□ Triluma	□ Metrogel
□ Finacea (Azelia Acid)	□ Differin	□ Tretinoin	□ Sulfur

□ Tetracycline treatments within the last month

SUN PROTECTION:

Do you ever use sunscreen? □Yes □ No How often? _____ What level of protection (SPF number?) _____

Most recent prolonged sun exposure? _____

PHOTOGRAPHIC CONSENT:

I give consent to be photographed for the purpose of medical records □ Yes □ No
I give the consent to be anonymously photographed for marketing and/or publication □ Yes □ No

Patient Signature _____ **Date** _____

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Fitzpatrick Skin Type Form

Score	0	1	2	3	4
What color are your eyes?	light blue, grey, green	blue, gray or green	blue	dark brown	brownish black
What is the natural color of your hair?	sandy red	blonde	chestnut/ dark blonde	dark brown	black
What is the color of your skin (non-exposed areas)?	reddish	very pale	pale with beige tint	light brown	dark brown
Do you have freckles on unexposed areas?	many	several	few	incidental	none
	← **Total score for genetic disposition**				
Score	**0**	**1**	**2**	**3**	**4**
What happens when you stay too long in the sun?	painful redness, blistering, peeling	blistering, followed by peeling	burns sometimes followed by peeling	rare burns	never had burns
To what degree do you turn brown?	hardly or not at all	light color tan	reasonable tan	tan very easy	turn dark brown quickly
Do you turn brown within several hours of exposure?	never	seldom	sometimes	often	always
How does your face react to the sun?	very sensitive	sensitive	normal	very resistant	never had a problem
	← **Total score for reaction to sun exposure**				
Score	**0**	**1**	**2**	**3**	**4**
When did you last expose your body to sun (or artificial sunlamp/ tanning cream?)	more than 3 months ago	2-3 months ago	1-2 months ago	less than a month ago	less than 2 weeks ago
Did you expose the area to be treated to the sun?	never	hardly ever	sometimes	often	always
	← **Total score for tanning habits**				

Summary

	← Total score for genetic disposition
	← Total score for reaction to sun exposure
	← Total score for tanning habits
	← **Skin type score**

Your Fitzpartick Skin Type

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
over 30	V

Patient Signature _____ **Date** _____

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Medical Aesthetics & Laser

HIPPA Release Form
Cancellation Policy

Medical Aesthetics and Laser is very serious about our client's confidentiality.

Release of Information

□ I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

□ Spouse_____
□ Child(ren) _____
□ Other_____

□ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Cancellation/No Show Policy

Please contact Medical Aesthetics and Laser 24 hours prior to your scheduled appointment date and time to avoid cancellation fees.

Clients who do not cancel at least 24 hours prior to their appointment time and clients who fail to show up for an appointment without notice, will be charged a $50.00 fee. Appointments cancelled or missed for Halo, Ultherapy, Scarlet, Agnes and/or Coolsculpting will result in a fee of $100.00.

This Policy applies to New & Existing Clients.

We reserve the right to refuse appointments to any client who has demonstrated disregard of our cancellation policy.

I understand the cancellation policy and agree to its terms.

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____

BHRT Checklist For Women

Name: _____ **Date:** _____

E-Mail:_____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

BHRT CHECKLIST FOR MEN

Name: _____ **Date:** _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		