

Aesthetic Medicine History & Registration:

Last Name: _____ First: _____ [_____] DOB: _____

Address: _____ City: _____ Zip: _____ Age: _____

Cell: _____ email: _____ Occupation(s): _____

What is your preferred pronoun? [He/ She/ They / _____] If you wish to self-describe your gender: _____

What skin and body conditions/areas would you like treated? _____

What is your **ethnic** background? _____ Referred by: _____

Which best describes **your skin type**?

- I. Always burn, never tan
- II. Always burn, sometimes tan
- III. Sometimes burn, always tan
- IV. Rarely burn, always tan
- V. Brown, moderately pigmented skin
- VI. Black colored skin

Have you had **prior Aesthetic Treatments**? Botox? Fillers? Surgery? Please list: _____

List any medications, blood thinners, vitamins, supplements, topical products, steroids or aspirin you take Are you taking any blood thinners (aspirin, nonsteroidal anti-inflammatory drugs, and warfarin), or do you consume blood-thinning supplements (fish oil, vitamins C & E, ginkgo, ginseng, ginger) _____

Please Answer Questions if Yes:

1. List any **allergies** or sensitivities (Medications, food, latex, ultrasound gel): _____
2. Any **surgeries**? (Appendix removal) _____
3. Any **metal on or in** your body? a **metal implant** (pacemaker, hip replacement, cardiac wires); **Tattoos**, or **IV Gold** Therapy? _____
4. List if you have you taken **Accutane**, or Retin-A in the last 6 months: _____
5. Any history oral Herpes or Herpes I or II in the area to be treated? _____
6. List recent **unprotected sun** exposure, **sunburn**, use tanning creams or bed in the last 6 weeks: _____
7. List broken skin, active inflammation, recent infection, loss of sensation in the area to be treated: _____
8. If you faint (vasovagal) easily: _____
9. Recent use of Chemical Peels or a skin Bleacher? _____
10. Use topical skin care prescribed or over-the-counter? _____
11. Had a recent illness, viral infection, or see a physician for a reason? _____
12. Could be pregnant or been told you have Polycystic Ovarian Syndrome? _____
13. **Any current or chronic skin conditions or medical conditions** such as: heat urticarial, diabetes, cancer, autoimmune condition, viral infection, vitiligo, eczema, psoriasis, Keloid tendency, collagen disorder (Ehlers-Danlos Syndrome), skin cancer, skin photosensitivity disorder, or any current or chronic skin condition? _____

Privacy/ Media / Billing Policies:

1. Photographs are taken for your clinical records and review by your providers. Please specify if you allow sharing these photos:
 - o in-office only
 - o Photographs and/or videos may be shared on **public media** with privacy blinders.
2. Besides check or cash, we accept Venmo business (2% fee), and all credit cards (3% fee).
3. Please leave jewelry and valuables at home since removal of such items may be needed for your treatments.
4. I am aware of the privacy and payment policies of the practice and have no further questions.

Signature: X _____ Date: _____

Witness: _____ M / F / _____ [update 6.2.23]

Attn/ SHx: