Full Name (Last, First, MI.) _____ **Date of Birth** / / **Today's Date** / /

Gender M / F **Height** _____ **Weight** _____

Email _____

FOR OFFICE USE ONLY
____ Consultation Completed
____ Intake & Health History Reviewed
____ Pre-care/Post-care Given
Signature: _____

Phone Numbers *Provide your contact number(s) and check the box below for your preferred contact number.* **May we leave a detailed message?**

☐ **Home** _____ ☐ **Mobile** _____ ☐ **Work** _____ ☐ **Yes** ☐ **No**

Home Address _____ **City/State** _____ **Zip Code** _____

Facebook **Yes/No** **How did you hear about us?**

Medical History *Select past and present medical conditions you have experienced*

☐ **None**
☐ *Hypertension (High Blood Pressure)*
☐ *Hypotension (Low Blood Pressure)*
☐ *HIV*
☐ *Herpes/Cold Sores*
☐ *Skin Disease*
☐ *Hormone Therapy*
☐ *Diabetes*
☐ *Heart Disease/Condition*
☐ *Organ Transplants*
☐ *Metal/Bone/Cement Implants*
☐ *Pacemaker/Other Electrical Implants*

Cancers Other Than Skin: *Include type/location and treatment(s)* _____

Additional Medical Conditions: _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Past Surgeries *None or List Past Surgeries*

☐ **None** _____

Skin Disease History *None or List All Skin Diseases and/or Disorders*

☐ **None**
☐ *Eczema*
☐ *Seborrheic Dermatitis*
☐ *Warts*
☐ *Acne*
☐ *Psoriasis*
☐ *Rosacea*
☐ *Ichthyosis*
☐ *Actinic Keratosis*
☐ *Contact Dermatitis*
☐ *Vitiligo*
☐ *Keratosis Pilaris*
☐ *Melasma*
☐ *Skin Cancer*
☐ *Other:* _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what brand/SPF? _____

Tanning salon usage? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

Medication History

List all medication names and dosages including over the counter, herbal supplements, prescription creams & skin care products.
(Examples: Retin-A, Renova, Differin, Tazorac, glycolic/AHA products)

_____
_____
_____
_____
_____
_____

Social History

Do you use tobacco products? ☐ Yes ☐ No If yes, what type & how much? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how often & how much? _____

What is your occupation? _____

Cosmetic History

Have you had any plastic surgery? ☐ Yes ☐ No If yes, what type/when? _____

Have you had laser skin resurfacing? ☐ Yes ☐ No If yes, what type/when? _____

Have you had Botox or Dermal Fillers? ☐ Yes ☐ No If yes, when? _____

Have you had Laser Hair Removal? ☐ Yes ☐ No If yes, when/what area(s) of your body? _____

Have you had any permanent makeup? ☐ Yes ☐ No If yes, when/what area(s) of your face? _____

Please list any other cosmetic procedure you've had in the past or receive regularly:

_____

_____

_____

Skin Concerns

☐ **None**	☐ *Fine Lines*	☐ *Texture*	☐ *Sun Spots*
☐ *Whiteheads*	☐ *Wrinkles*	☐ *Acne*	☐ *Aging*
☐ *Blackheads*	☐ *Redness*	☐ *Dull*	☐ *Dark Circles*
☐ *Enlarged Pores*	☐ *Irritation*	☐ *Laxity*	☐ *Oily*
☐ *Dry/Flaky*	☐ *Dehydrated*	☐ *Scarring*	☐ *Pigmentation*
☐ *Other:*			

_____

Cosmetic Interests

Please check any cosmetic services you are interested in receiving or learning about:

☐ **None**	☐ *Lash Extensions*	☐ *Waxing*	☐ *Microneedling*
☐ *Facials*	☐ *Lash Lift*	☐ *Chemical Peels*	☐ *Teeth Whitening*
☐ *Hydrodermabrasion*	☐ *Lash Tint*	☐ *Body Contouring*	☐ *Tooth Gem*
☐ *Microdermabrasion*	☐ *Brow Tint*	☐ *Permanent Makeup*	☐ *Lip Enhancement*
☐ *Light Therapy*	☐ *Brow Lamination*	☐ *Vajacial*	☐ *Make-up*
☐ *Other:*			

_____

Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Signature: _____ Date: _____

Print Name: _____