Medical Intake Form

Name_______________ DOB _______________ Today's Date_______________

Address_______________

City/St/Zip_______________

Height_______________ Weight_______________ Allergies_______________

Cell Phone_______________ Home Phone_______________ E-Mail (print)_______________

Occupation _______________ How did you hear about us? _______________

Circle all Medical Conditions:

Bleeding tendency/Diabetes/Blood Transfusions/Glaucoma/Dry eyes/Lung Disease/TB/ Asthma/Emphysema/Bronchitis/Irregular heartbeat/Chest pain/Heart Disease/Stroke/ Heart Attack/Heart Burn/Epilepsy/High Blood Pressure/Ulcers or Bleeding/ Scleroderma/ Hepatitis B or C/HIV/Rheumatoid Arthritis/Lupus/Porphyria/Depression/Mental Illness/ Drug or Alcohol Addiction/ None of the above/Any other serious illness or injury_______________

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Please list all current medications you are taking and/or you have used in the past 6 months including: Birth Control, Aspirin or ibuprofen, Weight loss medication, Coumadin, or any blood thinning medication, prescription eye drops, steroids, or antibiotics

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List all surgeries you have had (including plastic surgery):

Date_______________ Surgery_______________

Date_______________ Surgery_______________

Date_______________ Surgery_______________

Have you ever seen a Dermatologist for your skin	Yes	No	Reason? _______________
Are you pregnant or lactating?	Yes	No	How many months _______________
Have you ever taken Accutane?	Yes	No	When? _______________
Do you have a history of Herpes Simplex (cold sores)?	Yes	No	Last Outbreak?_______________
Do you have a history of developing Keloids (raised scars)	Yes	No	Describe _______________
Do you have regular periods?	Yes	No	
Do you smoke cigarettes or use tobacco products?	Yes	No	How often? _______________
Do you use recreational drugs?	Yes	No	How often?_______________
Do you drink alcohol?	Yes	No	How often? _______________

Circle all Skin Conditions

Eczema/Psoriasis/Melanoma or Skin Cancer/Acne/Rosacea/Vitiligo/Other _______________

Have you ever been diagnosed with cancer? Yes No

What kind and when?_______________

What topical medications do you use? (Retina A, Salicylic Acid, Glycolic Acid, Benzoyl Perozide, Antibiotics)

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What vitamins or supplements are you currently taking?

____

List all current skin care products _______________

I am aware of the 48 hour cancellation policy. There will be a $50 charge per hour or portion thereof, for any treatment not cancelled at least 48 hours in advance.

Signature:_______________ Date:_______________