SkinnyMe with hCG

AESTHETICS PATIENT PROFILE

Name:_____ DOB:_____ Today's Date:_____

Address: _____

City / State/ Zip: _____

Cell Phone: _____ Home Phone: _____

Height: _____ Weight: _____ Allergies: _____

Email:_____ Occupation:_____

Primary Physician: _____ Phone Number: _____

Emergency Contact: _____ Emergency Phone: _____

How did you hear about us?

_____

Which of the Following best describes you?

- Always Burns, Never Tans
- Always Burns, Sometimes tans
- Sometimes Burns, Usually Tans
- Rarely Burns, Tans Easily
- Moderately Pigmented, Never Burns

Please Complete Fitzpatrick Skin Typing Below:

African American	☐	Hispanic	☐	Native American	☐
Asian	☐	Mediterranean	☐	Other: _____	
Caucasian	☐	Middle Eastern	☐		

What area would you like to treat Today?

_____

Would you like more information about any other areas or services that we may provide? If yes,

_____

_____

Please answer all the following questions:

Have you ever seen a Dermatologist? ☐ Yes ☐ No Reason? _____

Are you pregnant or Lactating? ☐ Yes ☐ No How many months? _____

Have you ever taken Accutane? ☐ Yes ☐ No When? _____

Do you have history of Herpes Simplex? ☐ Yes ☐ No Last Outbreak? _____

Do you have a history of developing Keloids? ☐ Yes ☐ No Describe: _____

Do you have regular periods? ☐ Yes ☐ No Last Period? _____

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? _____

Do you have any Skin Disorders? ☐ Yes ☐ No Type? _____

Do you have an ACTIVE Skin Disease? ☐ Yes ☐ No If yes _____

Do you have HIV or AIDS? ☐ Yes ☐ No Diagnosis Date: _____

Do you wear contact lens? ☐ Yes ☐ No

Are you a Diabetic or have an endocrine disorder? ☐ Yes ☐ No

Do you have Hepatitis? ☐ Yes ☐ No

Do you have PCOD, Hirsutism or thyroid disease? ☐ Yes ☐ No

Do you have any heart or lung disease? ☐ Yes ☐ No

Do you have a pacemaker or deliberator? ☐ Yes ☐ No

Do you have high Blood pressure? ☐ Yes ☐ No

Do you medications that cause photosensitivity? ☐ Yes ☐ No

Do you have Blood Disorders? ☐ Yes ☐ No

Are you on any blood thinners? (Coumadin, Warain, Asprin)? ☐ Yes ☐ No

Have you ever had DTV? (Deep Vein Thrombosis) ☐ Yes ☐ No

Do you have any body art or piercing in the area being treated? ☐ Yes ☐ No

Does your skin remain discolored after healing from a cut or wound ☐ Yes ☐ No

Skin Care

Please check all that applies to you:

- ☐ Contagious Skin condition
- ☐ Circulatory disorder
- ☐ Open sores or Wounds
- ☐ Bruises easily
- ☐ Recent accident or injury
- ☐ Recent fracture or surgery
- ☐ Artificial joints
- ☐ Sprains/ Strains
- ☐ varicose veins
- ☐ Phlebitis
- ☐ Deep Vein Thrombosis/Blood Clots
- ☐ Joint Disorder/ Arthritis /Osteoarthritis
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ Current Fever
- ☐ Swollen Glands
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ Decreased Sensation
- ☐ Carpal Tunnel
- ☐ High/Low BP
- ☐ Heart Condition

What is your daily skin routine?

Dayitme: _____

Evening: _____

Skin History

How would you describe your skin? Dry ☐ Oily ☐ Combination ☐ Mature ☐ Sun-damaged ☐

Acne Grades 1&2 ☐ Acne Grades 3&4 ☐ Rosacea/Broken ☐ Capillaries ☐ Large pore Size ☐

Scarring and/or Acne scarring ☐ Discoloration ☐ Uneven Skin Tone ☐

Females: Do you suffer from hormonal hair growth on upper lip, chin, and/or chest? Yes ☐ No ☐

How often are you in the sun? Frequently ☐ Occasionally ☐ Rarely ☐

Have you or any member of your family had skin cancer? Yes ☐ No ☐

How often do you use sun screen? Frequently ☐ Occasionally ☐ Rarely ☐

Which is your skin tone? Very Fair ☐ Fair ☐ Medium ☐ Medium-Olive ☐ Dark ☐ Very Dark ☐

Do you prefer extraction when you have a professional facial treatment? Yes ☐ No ☐

I certify that, to the best of my knowledge, that the information that I have provided in this form are accurate. I understand that this information is confidential and will not be disclosed without my written consent. I understand that should anything change with my medical history during my treatment regime, that I will let the staff know of the changes before any other treatments ate preformed.

_____ _____

Patient Signature **Date**

_____ _____

Physician Signature **Date**