Intake & Health History

Name			Date
Cell #	Home #		Email
Address		City/State	Zip
DOB	Age	Gender	Occupation
Emergency Contact Name		Phone #	Relationship

Please list all Medical Allergies: _____

Please list all Skin Allergies: _____

☐ Yes ☐ No Are you sensitive to any of the following? Detergents/Soaps Fabrics Lotions/Creams Perfumes

Medical History: Please indicate if you have experienced or are experiencing any of the following conditions:

☐ Yes ☐ No Do you have any chronic medical conditions? If yes, please list: _____

☐ Yes ☐ No Are you currently in treatment for any medical conditions? If yes, please list: _____

☐ Yes ☐ No Are you currently under the care of a physician or dermatologist? If yes, please state reason: _____

☐ Yes ☐ No Do you use a sunscreen / sunblock?

☐ Yes ☐ No Do you participate in outdoor activities? If yes, when was your most recent sun exposure? _____

☐ Yes ☐ No Do you have a history of skin cancer? If yes, please describe: _____

☐ Yes ☐ No Have you had permanent cosmetics? If yes, please indicate location(s): _____

☐ Yes ☐ No Are you currently taking Accutane or have you been on it within the past year?

☐ Yes ☐ No Have you ever had herpes? If yes, please state treatment medications: _____

☐ Yes ☐ No Are you currently taking medication(s)? If yes, please list all medications: _____

☐ Yes ☐ No Are you currently taking any vitamins or supplements? If yes, please list:

☐ Yes ☐ No Are you pregnant, or planning to become pregnant?

☐ Yes ☐ No Are you currently on hormone replacement therapy?

☐ Yes ☐ No Have you had any of the following: ☐ Botox ☐ Filler ☐ Chemical Peel ☐ Cosmetic Surgery ☐ Laser Resurfacing

Other (please specify): _____

☐ Yes ☐ No Are you currently using any of the following:

☐ Differin ☐ Hydroquinone ☐ Retin A ☐ Renova ☐ Tazarotene ☐ Tretinoin

Which skin conditions do you want to improve?

☐ Acne/Acne Scarring ☐ Age Spots ☐ Enlarged Pores ☐ Fine Lines & Wrinkles ☐ Hyperpigmentation ☐ Sun Damage

Other: _____