

Date: _____

Medical Intake Form

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

Emergency Contact: (Name & Phone) _____

Primary Physician: _____

Do we have permission to contact you by phone or leave messages: Yes No

Preferred method of contact: Phone Text E-Mail

Do we have permission to show your photos for educational purposes? Yes No

Concerns

What concerns you most about the overall appearance of your skin? (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Acne Scarring | <input type="checkbox"/> Age Spots |
| <input type="checkbox"/> Blackheads | <input type="checkbox"/> Body Acne | <input type="checkbox"/> Broken Blood Vessels |
| <input type="checkbox"/> Bumps on back of arms | <input type="checkbox"/> Cellulite | <input type="checkbox"/> Cysts/Nodules |
| <input type="checkbox"/> Dehydrated Skin | <input type="checkbox"/> Dull Complexion | <input type="checkbox"/> Excessive Facial Hair |
| <input type="checkbox"/> Facial Veins | <input type="checkbox"/> Fine Lines/Wrinkles | <input type="checkbox"/> Frequent Breakouts |
| <input type="checkbox"/> Large Pores | <input type="checkbox"/> Loss of Lashes/Brows | <input type="checkbox"/> Melasma/Brown Spots/Patches |
| <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Redness | <input type="checkbox"/> Rough/Uneven Skin Texture |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Sagging Skin | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Under Eye Puffiness/Dark Circles | <input type="checkbox"/> Other: _____ | |

How would you describe your skin? Oily Dry Combination Sensitive

How would you describe your stress level? Little Moderate High Severe

Do you feel your stress level may be affecting the health of your skin? Yes No

Are you in good health overall? Yes No Concerns: _____

History

Are you currently under the care of a physician? ___Yes ___No Explain:_____

Do you have any allergies to foods or medications? ___Yes ___No

Explain:_____

Are you currently on any medications either topical or oral? ___Yes ___No If yes, please list:

Ethnic Background (Parents, Grandparents and Great Grandparents): _____

How do you heal after an acne breakout, cut or scratch? ___ No scar ___ Red ___ Brown (PIH) Do

you smoke? ___Yes ___No Are you prone to cold sores? ___Yes ___No If yes, date of last cold sore?

_____ Do you have an allergy to Latex? ___Yes ___No Do you tan in the sun or in

tanning beds/booths? ___Yes ___No Please check the skincare products you are currently using:

___Cleanser ___Toner ___Serum ___Scrub ___Mask ___Eye Cream ___Moisturizer

___Sunscreen ___Self Tanner ___Concealer ___Makeup ___Other_____ Anything

else we should know:_____

The answers I have provided are true and correct to the best of my knowledge.

Client Signature

Date

Provider Signature

Date