SKINRITUAL

aesthetic clinic

Patient Intake Form

Name: _____ DOB: _____/_____/_____ Date: _____/_____/_____

Phone Number: _____ Email: _____

Would you like to receive emails about office specials/promotions? (Please check) Yes ____ No ____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? (Please check all that apply)

___Instagram Account: (circle one) @the_aesthetician @the_dermgirl @fox_derm

@jennayount_aesthetics @lexihorn_aesthetics @the_skinritual @desert_sky_derm

___Desert Sky Dermatology ___Friend/Family:_____

___Yelp ___Google ___Facebook ___Dermatologist Other: _____

Reason for visit: _____

What is your current daily skin care regimen?

_____

_____

Previous Procedures: Which of the following have you had in the past? (Please check all that apply)

___ Botox, Dysport, Xeomin, Jeuveau

___ Injectable Fillers (i.e. Juvederm, Restylane, Voluma)

___ Facials

___ Microdermabrasion

___ Dermaplaning

___ Chemical Peels

___HydraFacial/Dermalinfusion

___ Clear + Brilliant laser

___ Laser Hair Removal

___ Permanent Makeup or Microblading

___ Laser Resurfacing(i.e. Fraxel, Halo, CO2)

___ Photofacial/IPL/BBL

___ Microneedling (with or without PRP?)

___ Vivace/RF Microneedling

___ Facial Cosmetic Surgery:_____

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Name: _____ DOB: _____/_____/_____ Date: _____/_____/_____

Current Medications: (Including topical medications like Retin-A, tretinoin, etc.)

_____

_____

_____

Allergies: (Including latex, medications, food, etc.)

_____

_____

_____

Are you pregnant? Y N Are you nursing? Y N Are you planning on becoming pregnant? Y N

Are you currently taking ACCUTANE, or have you taken Accutane in the last 6 months? Y N

Do you use tanning beds? Y N Do you wear sunscreen DAILY? Y N Do you smoke? Y N

Any Dental work/cleaning in the last 2 weeks, or an upcoming appointment in the next 2 weeks? Y N

Past Personal Medical History: (Please check all that apply)

___Autoimmune Disease ___IUD (current) ___Lyme Disease

___Hyperthyroid ___Diabetes ___Lupus

___Hypothyroid ___Fibromyalgia ___Metal Implants or Plates

___Blood Clots, Bleeding Disorders ___Heart Disease ___PCOS

___Cancer ___Hepatitis B or C ___Seizures

___Cold Sores (ever, even years ago) ___Hormone Therapy ___Stroke

___ Connective Tissue Disorder ___High Blood Pressure ___Hysterectomy

___HIV/AIDS ___Cochlear implant, Pacemaker, Defibrillator, or any other electrical devices

Other: _____

Past Personal Skin History: (Please check all that apply)

___Undiagnosed Skin Lesions ___Keloid Scars ___Psoriasis

___Actinic Keratosis (pre-cancer) ___Melasma/“pregnancy mask” ___Shingles

___Eczema ___Pigment Disorder (i.e. Vitiligo) ___Rosacea

___Skin Cancer – circle all that apply: Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma

Previous Surgeries: _____

_____