# Medical Intake Form

Name:_____ Birth Date:_____

Address: _____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Work Phone:_____

E-Mail:_____

Emergency Contact: (Name & Phone)_____

Primary Physician: _____

Do we have permission to contact you by phone? _____Yes _____No

Do we have permission to show your non-identifying photos for educational purposes? _____Yes _____No

Concerns

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

| | | |
|---|---|---|
| ___Acne | ___Acne Scarring | ___Age Spots |
| ___Blackheads | ___ Body Acne | ___Broken Blood Vessels |
| ___Bumps on back of arms | ___Cysts/Nodules | ___Dehydrated Skin |
| ___Dull Complexion | ___Excessive Facial Hair | ___Facial Veins |
| ___Fine Lines/Wrinkles | ___Frequent Breakouts | ___Large Pores |
| ___Melasma | ___Oily Skin | ___Redness |
| ___Rosacea | ___Rough/Uneven Skin Texture | ___Sun Damage |

___Other:_____

How would you describe your skin?

___Oily ___Dry ___Combination ___Sensitive

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:_____

_____

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_____

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

_____ _____

Client Signature Date

_____ _____

Provider Signature Date