

facialaesthetics

NEW PATIENT INFORMATION SHEET

Today's date: _____ E-mail Address: _____
Patient name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ Age: (Optional) _____ Sex: _____
Marital Status: S: _____ M: _____ Div: _____ W: _____
Patient Employer _____ Position _____
Spouse Name: _____ Employer: _____
In Case of Emergency Call: _____ Phone: _____
Relationship: _____

Is it important to you that treatments are done in a medical setting? Yes ___ No ___

WHAT SERVICES ARE YOU INTERESTED IN?

- | | |
|---|---|
| <input type="checkbox"/> Peels | <input type="checkbox"/> Comprehensive Vein Therapy |
| <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> IPL/Wrinkle Reduction™ |
| <input type="checkbox"/> Facials | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Acne Treatment | <input type="checkbox"/> Make-up / Makeovers |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> LED |
| <input type="checkbox"/> Dermal Fillers: (circle)
Cosmoplast™ / Evolence® /
Restylane® / Radiesse™ / Sculptra®/
Juvéderm™ / Perlane® | <input type="checkbox"/> Waxing |
| <input type="checkbox"/> Visia® Skin Analysis | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> BOTOX® Cosmetic |
| | <input type="checkbox"/> DOT Therapy |

HOW WERE YOU REFERRED TO FACIAL AESTHETICS?

- | | |
|---|--|
| <input type="checkbox"/> Dr. John Grossman | <input type="checkbox"/> Dr. Philippe Capraro |
| <input type="checkbox"/> F/A Patient: _____ | <input type="checkbox"/> Staff: _____ |
| <input type="checkbox"/> Mailer/Postcard | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Event | <input type="checkbox"/> Radio |
| <input type="checkbox"/> TV Channel | <input type="checkbox"/> Charity/ Silent Auction |
| <input type="checkbox"/> Website | <input type="checkbox"/> Other _____ |

FOR CLINIC USE ONLY	Site:	Next Appt:
Specialist:	Treatment:	
Last Name:	First Name:	Purchased:

facialaesthetics

Medical Health and History

My Doctors

My regular internist is: _____

My dermatologist is: _____

My gynecologist is: _____

My plastic surgeon is: _____

My Habits

I smoke: Yes No

If Yes, how often: _____

I drink: Yes No

If Yes, how often: _____

I use drugs Yes No

If Yes, how often: _____

My Allergies

I am allergic to the following medications: _____

I am allergic to the following foods: _____

I am allergic to the following skin care products or ingredients: _____

I react to "caine" products: Yes No

I have had an anaphylactic reaction: Yes No

I have had a bad reaction to a dental shot: Yes No

I faint easily: Yes No

My Surgeries

I have had the following *recent* surgeries:

Surgical Procedure: _____ Date: _____

Surgical Procedure: _____ Date: _____

Surgical Procedure: _____ Date: _____

Surgical Procedure: _____ Date: _____

My Medications

I use anti-inflammatory drugs such as aspirin, Motrin or Advil:

Yes No If yes, they are:

I take heparin or comadin: Yes No If yes, they are:

I take AZT or related drugs: Yes No If yes, they are:

I take anti-histamines: Yes No If yes, they are:

I take Immunosuppressives: Yes No If yes, they are:

I take desensitizing allergy medications:

Yes No If yes, they are:

I take herbal medications: Yes No If yes, they are:

I take oral cortisone: Yes No If yes, they are:

I take Antibuse or Flagel: Yes No If yes, they are:

I take HRT: Yes No If yes, they are:

I take thyroid replacement: Yes No If yes, they are:

I take anti-depressants: Yes No If yes, they are:

I take or have taken Accutane with in the past 6 months: Yes No

Other medications I take are: _____

My Chronic Illness

I have an Autoimmune Disease: Yes No If yes, the name: _____

I have or have had asthma: Yes No

I have or have had eczema: Yes No

- I have or have had hay fever: Yes No
- I have or have had itchy episodes: Yes No
- I have or have had rashes of unknown origin: Yes No
- I have epilepsy or a history of seizures: Yes No
- I have Hepatitis: Yes No Type: A B C
- I have Herpes: Yes No
- I have High Blood Pressure: Yes No
- I have a Heart Problem or Irregular heart beat: Yes No
- I have HIV or AIDS: Yes No
- I have depression or mental illness: Yes No
- I am pregnant: Yes No
 If yes, when are you due: _____ How many pregnancies: _____
- I am planning on getting pregnant: Yes No
- I am nursing: Yes No

Are you now or have you recently been treated for health problems:

Yes No If yes, please explain _____

My other chronic illnesses are: _____

My Skin

My mother's ethnicity is: _____

My father's ethnicity is: _____

My natural hair color is: _____

My eye color is: _____

I have freckles on exposed areas: Yes No

I have freckles on unexposed areas: Yes No

As a child I burned in the sun:

Always Sometimes Rarely Never

As an adult I burn in the sun WITHOUT sun screen:

Always Sometimes Rarely Never

As an adult I burn in the sun WITH sun screen:

Always Sometimes Rarely Never

I have had skin cancers: Yes No If Yes, where: _____

My skin cancers are: Basal Cell Squamous Cell Melanomas

I use sun screen everyday: Yes No If yes, what SPF: _____

I tan in the summer: Yes No

I use a tanning bed: Yes No

I am currently tan or sunburned: Yes No

My Skin Care Products

I use a cleanser every morning and evening: Yes No

Comments: _____

I use a toner every morning and evening: Yes No

Comments: _____

I use a moisturizer every morning and evening: Yes No

Comments: _____

I use Retin A or Renova: Yes No Comments: _____

I use an Alpha Hydroxy Acid: Yes No Comments: _____

I use Vitamin C or other topical vitamins on my skin everyday: Yes No

I think my skin is sensitive: Yes No Comments: _____

My skin has allergies: Yes No Comments: _____

I don't like products that: _____

I LIKE products that: _____



Patient Agreement

At Facial Aesthetics we strive to provide the best treatments and quality of service in a professional and on-time manner.

If you are unable to keep the appointment that you scheduled, we kindly ask that you contact our office to cancel the appointment within 24 hours.

We realize that your time is valuable and hope that you can extend the same courtesy to your clinician.

*We confirm appointments by phone 24 hours in advance. We also confirm appointments by **email** and **text message**. Please specify how you would prefer we confirm your appointment:*

Email *Text Message* *Phone*

(If you prefer email, please make sure we have your email address)

We reserve to right to assess a \$50 charge for missed appointments.

I understand the above policy and agree to comply.

Signature: _____

Date: _____