Patient Profile Sheet

Last Name ________________First__________________ Middle_______________

Address_____________________________________ City_____________________

State_____ Zip________ Birth Date____________ Date of First visit______________

Home Phone____________ Work Phone____________ Cell Phone______________

Email_______________________ Do you check email regularly? Yes No

Referred by____

I understand that I will receive a reminder call for my next appointment.
Please call my __________ phone.

Patient History

Have you ever taken Accutane? Yes No When______ Dosage ______Months_______
Have you ever used Tretinoin? Yes No __________%
Do you use birth control pills? Yes No Are you currently pregnant? Yes No
Are you attempting pregnancy? Yes No Are you breastfeeding? Yes No
Do you have fever blisters ? Yes No Valacyclovir Zovirax Valtrax
Do you use tanning beds? Yes No Current Medications______________________
Do you use mineral make-up? Yes No Allergies______________________________

Are you interested in the following? (check all that apply)

Botox
Line fillers (Restylane/Collagen)
Microdermabrasion
Chemical Peels
Facials
Mineral Make-up
Hair Removal________________________
Vein Treatment_______________________
Skin Tightening
Permanent Make-up
Pigmented Lesions Removal
Skin Care

Areas of Patient Concern

Lines/wrinkles
Skin texture
Skin hydration
Unwanted hair
Skin elasticity
Even skin tone
Skin laxity
Skin pigmentation
Skin disorder
Acne scars
Acne

Other concerns_____________________

Current Skin Care Products Used

Cleanser- ______________ Eye Cream-______________AHA-_________________
Toner-________________ L-ascorbic acid-___________Make-up-______________
Moisturizer-_____________ Anti-aging serum-__________Sunscreen______________