



Rodonaia
Family Medicine
& Aesthetics

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Aesthetic Patient Intake Form

Date: _____
 Name: _____ DOB: _____
 Address: _____
 City / Zip: _____ Email: _____
 Day Phone: _____ Evening Phone: _____
 Emergency Contact Name: _____ Phone: _____
 Occupation / Workplace: _____
 Current Physician: _____ Phone: _____

GENERAL HEALTH

Allergy: Medications _____
 Allergy: Cosmetics _____
 Allergy: Latex/Other _____

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Skin Problems Type (redness, rashes, hives, heat sensitivity) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Fainting | Used or currently using: |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Retin-A, Retinoic Acid Products |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Accutane, TriLuma, Tazorac |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prescription Acne Medication |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Birth Control (pills, patch, etc...) |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Steroids (cortisone) |
| <input type="checkbox"/> Infection (active) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Melanoma | |
| <input type="checkbox"/> Mental Disorder | List all current medications/supplements: |
| <input type="checkbox"/> Metal Implants/Pacemaker | _____ |
| <input type="checkbox"/> Nervous Disorder | _____ |
| <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Sinus Problems | _____ |

Previous Cosmetic Facial Treatments:

Acid Peel	Yes	No	Date: _____
Botox	Yes	No	Date: _____
Collagen	Yes	No	Date: _____
Tattoo/Perm Makeup	Yes	No	Date: _____
Waxing	Yes	No	Date: _____
Facial Surgery	Yes	No	Date: _____
Laser Surgery	Yes	No	Date: _____
Microderm Abrasion	Yes	No	Date: _____
Other _____	Yes	No	Date: _____

TOPICAL SKIN HISTORY:

Skin Type:	Normal	Oily	Dry	Sensitive	Combination
How often do you tan?	Daily	Weekly	Often	Seldom	Never

What type of skin care methods do you practice?

Cleanser _____ Toner _____ Moisturizer _____
Eye Cream _____ Mask _____ Sunscreen _____

Other _____

Any past product(s) reactions? Explain _____

What are your primary skin concerns? _____

EMOTIONAL-CARE:

Are you under a lot of stress? _____ Rate stress 1-10 _____

Do you exercise regularly? _____

How do you prefer massage? Light Medium Firm

Is there anything about your skin that you would like to improve or change?

PLEASE INDICATE THE FOLLOWING:

Do you have any metal implants (pacemaker, braces, fillings) Yes No

Have you recently had x-rays Yes No

Have you had any recent injury(ies) Yes No

Please explain: _____

Do you have any concerns regarding nutrition: _____

How did you hear about our facility: _____

FOR OFFICE USE ONLY:

Fitzpatrick Score: _____

Treatments Recommended: _____