Rodonaia
Family Medicine
& Aesthetics

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Aesthetic Patient Intake Form

SUBMIT 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:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Contact Lenses
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Hormonal Problems
- ☐ Infection (active)
- ☐ Melanoma
- ☐ Mental Disorder
- ☐ Metal Implants/Pacemaker
- ☐ Nervous Disorder
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Skin Cancer
- ☐ Skin Problems Type (redness, rashes, hives, heat sensitivity)
- ☐ Smoker
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Pregnant

Used or currently using:

- ☐ Retin-A, Retinoic Acid Products
- ☐ Accutane, TriLuma, Tazorac
- ☐ Prescription Acne Medication
- ☐ Birth Control (pills, patch, etc...)
- ☐ Steroids (cortisone)
- ☐ Other

List all current medications/supplements:

_____

_____

_____

_____

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: _____