Patient information as of today's date: ___________________________(Please print legibly and fill in all fields. If information is not available, please put N/ A).

Patient Information

Last Name ______________________________________ First Name____________________ DOB ___________________________

Address ____ Apt# _________________________

City ____ State_________________________ Zip ___________________________

Cell Phone (_______)_____________________________ Home Phone (_______)_______________________________________

Work Phone (_______)____________________________ Email Address ____

Emergency Contact Name/Phone Number _____________________________ /(_____)__________________________________

Date of last physical ____________________________ Name of Primary Physician _____________________________________

Is your general health good? Yes No

Personal Medical and Surgical History

Females: Are you pregnant? □ YES □ NO Are you breastfeeding? □ YES □ NO

1. List all Current and Past Medical Conditions/ Diagnosis: *Disclose any history of heat urticaria,* ***cold sores****, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness. Including skin conditions such as of vitiligo****, keloids*** *eczema,* ***melasma****, psoriasis,* ***allergic dermatitis****, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma,* ***skin cancer,*** *herpes simplex 1 and 2, or any other skin condition*

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2. Do you have any **open sores** or lesions? □ YES □NO

3. List **ALL** current medications including aspirin, ibuprofen, herbal remedies, blood thinners, etc: □ None

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____

4. **Allergie**s to medications, foods, latex, topical products or other substances □ None

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____

5. List **ALL** surgeries including cosmetic procedures with dates: □ None

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Please Answer All of the Following Questions

1.In the last six (6) months, have you used any of the following: **Anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications?** Please List product name and date last used:

____

2 . In the last three (3) months, have you used any of the following products:**Glycolic acid or other alphahydroxy or betahydroxyacid acid products**; exfoliating or resurfacing products or hyperpigmentation treatments? Please List product name and date last used:

____

3. Have you taken **Accutane®** (or products containing isotretinoin) in the last 12 months? ☐ YES ☐NO

4. Have you taken **Tretinoin** (like Retin-A, Renova) in the last 6 months? ☐ YES ☐NO

5. Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? Please List:____

6. Have you ever had any of the following injectables or implants:

☐ Botox ☐ Juvéderm ☐ Radiesse ☐ Restylane ☐ Perlane ☐ Silicone ☐ Hylaform

☐ Collagen ☐ Bellafill ☐ Sculptra ☐ Dysport Other:____________________

*If so, when was it done?____________________ What area?____________________________________

Please Answer the Following Questions:

Which concerns apply to you? (Check all that apply):

☐ Uneven Skin Tone
☐ Brown Spots (hyperpigmentation)
☐ White Spots (hypopigmentation)
☐ Visible Exposed Blood Vessels
☐ Hard Bumps Under Skin
☐ Dry Patches

☐ Enlarged Pores
☐ Clogged Pores
☐ Blackheads/whiteheads
☐ Acne
☐ Excessive oiliness
☐ Skin Laxity
☐ Upper Lip Lines
☐ Wrinkles

☐ Scarring
☐ Unwanted Hair
☐ Rosacea (redness on face, neck, or chest)
☐ Spider Veins
☐ Stretch Marks
☐ Cellulite
☐ Unwanted Body Fat
☐ Thinning Lashes

Other:____

What is your skin type: ☐ Dry ☐ Combination ☐ Oily ☐ Normal

Please Mark any Services You Would Like to be Educated On

• Physician Grade Skincare	• Ultrasound-Assisted Liposuction	• Mole Removal
• _Injectables (Botox, fillers, etc.)	• Fat Transfer to Buttocks or Face	• Laser Hair Reduction
• Liquid Facelift	• Eyelid Surgery	• Laser Skin Rejuvenation
• Facials	• Nose Surgery	• Varicose Veins Treatment
• Massage Services	• Ear Surgery	• Teeth Whitening
• Skin Lightening	• Sun Spot Reduction	• Rosacea Treatment

To the best of my knowledge, the information provided above is true and accurate. I agree to tell the staff of any changes to my health history or medications as they arise. I understand that information is necessary for your practice and will remain confidential. All efforts are routinely made to ensure privacy is upheld.

Printed Patient Name **Date** **Signature of Patient**

Practice Representative Name **Signature of Practice Representative**

MARIA ESPINEL EST. 2022 AESTHETIC LOUNGE