

Medical Intake Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: (name & phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: (name & phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Concerns:**

What concerns you most about the overall appearance of your skin? (Check all that apply)

\_\_\_\_Acne \_\_\_\_Acne Scarring \_\_\_\_Age Spots

\_\_\_\_Blackheads \_\_\_\_Broken Blood Vessels \_\_\_\_Bumps on arms

\_\_\_\_Cysts/Nodules \_\_\_\_Dehydrated Skin \_\_\_\_Dull Complexion

\_\_\_\_Excessive Facial Hair \_\_\_\_Facial Veins \_\_\_\_Fine Lines

\_\_\_\_Frequent Breakouts \_\_\_\_Large Pores \_\_\_\_Melasma

\_\_\_\_Oily Skin \_\_\_\_PIH \_\_\_\_Redness

\_\_\_\_Rosacea \_\_\_\_Rough/Uneven Skin Texture \_\_\_\_Sun Damage

\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your skin?

\_\_\_\_Oily \_\_\_\_Dry \_\_\_\_Combination \_\_\_\_Sensitive \_\_\_\_Reactive

How would you describe your stress level?

\_\_\_\_Low \_\_\_\_Moderate \_\_\_\_High \_\_\_\_Severe

**History:**

Are you currently under the care of a physician? \_\_\_\_Yes \_\_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food allergies? \_\_\_\_Yes \_\_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on any medications either topical or oral? \_\_\_\_Yes \_\_\_\_No If yes please list:

Do you Smoke? \_\_\_\_Yes \_\_\_\_No

Are you Prone to cold sores: \_\_\_\_Yes \_\_\_\_No

Do you have an allergy to latex? \_\_\_\_Yes \_\_\_\_No

Do you tan in the sun or in tanning beds/booths? \_\_\_\_Yes \_\_\_\_No

Please check the skincare products you are currently using:

\_\_\_\_Cleanser \_\_\_\_Toner \_\_\_\_Serum \_\_\_\_Mask \_\_\_\_Eye Cream \_\_\_\_Retinol

\_\_\_\_Moisturizer \_\_\_\_Sunscreen \_\_\_\_Self Tanner \_\_\_\_Concealer \_\_\_\_Makeup

\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The answers I have provided are true and correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature Date