



Facial and Chemical Peel IN-TAKE FORM

Name: _____ Date: _____

How did you hear about us? (Whom may we thank for your referral?) _____

E-mail Address at which we may contact you: _____

Birth date: _____ Occupation: _____ Employer: _____

Home Address: Street: _____ City: _____

State: _____ Zip: _____ Preferred Phone for Us to Contact You: _____

Emergency Contact Name: _____ Phone: _____

Dermatologist Name: _____ Phone: _____

- 1. Is this your first facial treatment? ___ Yes ___ No
2. What is the reason for your visit today?
3. What special concerns do you have?
4. Are you presently under a physician's care for any current skin condition or other problem? ___ Yes ___ No
5. Are you pregnant? ___ Yes ___ No
6. Are you taking birth control pills? ___ Yes ___ No If so, what type?
7. Hormone replacement? ___ Yes ___ No If so, what type?
8. Do you wear contact lenses? ___ Yes ___ No
9. Do you smoke? ___ Yes ___ No
10. Do you often experience stress? ___ Yes ___ No
11. Have you had skin cancer? ___ Yes ___ No
12. Are you currently or have you in the past used:
___ Azelex ___ Differin ___ Renova ___
___ Retin-A ___ Tazorac ___ Glycolic Acid ___ Salicylic Acid
If so, when and for how long?
13. Are you currently or have you ever used Accutane? ___ Yes ___ No
14. Do you have acne? ___ Yes ___ No
Experience frequent blemishes? ___ Yes ___ No
If so, how frequently?
15. Do you have any allergies to cosmetics, foods or drugs? ___ Yes ___ No
Please list
16. Are you presently taking oral or topical medications? ___ Yes ___ No
If so, please list:

Skin Care Brands Used: Cleanser: _____ Retinoid: _____

Moisturizer: _____

Exfoliant: _____ Sunscreen: _____ Eye Cream: _____ Serum

(Vit. C/E): _____

Cosmetics Used: _____

- Skin type:
Please check the one that best applies (throughout your life)
___ I Always burn, never tan (Caucasian)
___ II Always burn, sometimes tan (Caucasian)
___ III Sometimes burn, always tan (Caucasian)
___ IV Never burn, always tan (Light Brown)
___ V Moderately pigmented (Brown)
___ VI Black Skin

Privacy Statement

I, _____, have had full opportunity to read and consider the office's Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I am aware that I may have a copy of the office's Notice of Privacy Practices.

Signature: _____ Date: _____

01/19/15