

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: \_\_\_\_\_

Where did your ancestors come from? \_\_\_\_\_ Family History of Rosacea? Y / N

Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_ # Recent weight loss Y/N or weight gain Y/N If so, how much? \_\_\_\_\_

Past Medical History: Have you had any problems with: Skin: Y / N Easy Bruising: Y / N Blood Clots: Y / N

Excessive Bleeding: Y / N Heart / Lungs: Y / N Stomach / Intestines: Y / N Cancer: Y / N Joints: Y / N

Liver / Kidneys: Y / N Diabetes: Y / N Thyroid: Y / N Depression/Anxiety: Y / N

If you answered yes to any of the above OR have any other medical problems, please describe here: \_\_\_\_\_

What surgeries have you had: \_\_\_\_\_

Have you ever had a complication from surgery? \_\_\_\_\_

Medications you are taking: \_\_\_\_\_

Are you taking aspirin, aspirin-containing medications, Ibuprofen, vitamin E, krill oil, fish oil, flaxseed oil, omega-3, ginkgo, ginseng, garlic supplement, glucosamine, or green tea supplement? \_\_\_\_\_

Allergies to medications or latex: \_\_\_\_\_

Social: circle one: Married / Single / Divorced / Widowed/ Committed Relationship If widowed or divorced, date: \_\_\_\_\_

Skin Care Brands Used: Cleanser: \_\_\_\_\_ Sunscreen: \_\_\_\_\_ Moisturizer: \_\_\_\_\_

Retinoid: \_\_\_\_\_

### Esthetic History:

Have you had Botox? \_\_\_\_\_ Last injection \_\_\_\_\_ What clinic? \_\_\_\_\_

Have you had fillers? \_\_\_\_\_ Last injection \_\_\_\_\_ What clinic? \_\_\_\_\_

Have you had previous laser treatments? \_\_\_\_\_ When? \_\_\_\_\_ Clinic? \_\_\_\_\_ Why? \_\_\_\_\_

Have you had Chemical Peels? \_\_\_\_\_ Last treatment \_\_\_\_\_ Have you had Microdermabrasion? \_\_\_\_\_ Last treatment \_\_\_\_\_

Do you get cold sores? \_\_\_\_\_ When was your last outbreak? \_\_\_\_\_ What treatment do you use? \_\_\_\_\_

Do you have a history of implants/surgeries/scars in the treatment area? \_\_\_\_\_

Have you used Accutane in the last 6 months? \_\_\_\_\_ Hydroquinone in the last 12 months? \_\_\_\_\_

### Lifestyle:

How many blistering sunburns have you had in your life? \_\_\_\_\_

Do you wear sunscreen on your face, neck, and chest every day? \_\_\_\_\_

Do you regularly tan or get unprotected sun exposure? \_\_\_\_\_

Do you smoke? Y / N #Packs/d \_\_\_\_\_ # Years \_\_\_\_\_ Have you ever smoked? Y / N Packs/d \_\_\_\_\_ #Years \_\_\_\_\_ When quit? \_\_\_\_\_ pkys

How much alcohol do you drink per week? \_\_\_\_\_ What type? \_\_\_\_\_

How much exercise do you get per week? \_\_\_\_\_ hrs/day x \_\_\_\_\_ days/wk What type? \_\_\_\_\_

Would you say you have a lot of stress in your \_\_\_\_\_ job \_\_\_\_\_ family \_\_\_\_\_ finances? What type of regular relaxation to you get? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink \_\_\_\_\_ cow \_\_\_\_\_ soy \_\_\_\_\_ almond milk? How much per day? \_\_\_\_\_

How much do you drink per day of \_\_\_\_\_ Water \_\_\_\_\_ Coffee (caf / decaf) \_\_\_\_\_ Tea (black / green) \_\_\_\_\_ Diet beverage?

How many servings per day of \_\_\_\_\_ Fruits \_\_\_\_\_ Vegetables?

How many servings per day do you eat of whole grains (rice, quinoa, oatmeal, whole-grain bread/cereal) \_\_\_\_\_?

How many servings per day do you eat of refined flours or sugars (sweets, bakery, white bread) \_\_\_\_\_?

How many times per week do you eat of \_\_\_\_\_ frozen meals \_\_\_\_\_ fast food \_\_\_\_\_ trans fats \_\_\_\_\_ fried foods?

**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

## Cosmetic Interest Questionnaire

**General appearance concerns, treatments or products of interest to you (please check all that apply).**

<input type="checkbox"/> Dry Skin <input type="checkbox"/> Brown spots on face, hands, arms, or red/brown blotchiness on neck or chest (circle) <input type="checkbox"/> Rosacea <input type="checkbox"/> Red or blue face veins <input type="checkbox"/> Veins under Eyes <input type="checkbox"/> Facial redness <input type="checkbox"/> Leg veins(do not bulge) <input type="checkbox"/> Cherry angiomas on face +/- or body (circle) <input type="checkbox"/> Skin tags <input type="checkbox"/> Sebaceous hyperplasia <input type="checkbox"/> Large pores/Fine lines <input type="checkbox"/> Uneven skin texture <input type="checkbox"/> Dull Skin <input type="checkbox"/> _____	<input type="checkbox"/> Loose, sagging, crêpy skin on face, neck, arms, or abdomen (circle which) <input type="checkbox"/> Double Chin/ "Turkey waddle" <input type="checkbox"/> Loss of jaw line <input type="checkbox"/> Oily skin <input type="checkbox"/> Black- or White-heads <input type="checkbox"/> Pimples <input type="checkbox"/> Cystic acne <input type="checkbox"/> Acne scars <input type="checkbox"/> Red surgical scar <input type="checkbox"/> Wrinkled skin <input type="checkbox"/> Crêpy skin around eyes <input type="checkbox"/> Deep creases around mouth	BOTOX or XEOMIN <input type="checkbox"/> Frown line <input type="checkbox"/> Forehead lines <input type="checkbox"/> Crow's feet <input type="checkbox"/> Mini brow lift <input type="checkbox"/> Bunny lines FILLER for Creases: <input type="checkbox"/> Naso-labial folds <input type="checkbox"/> Marionette lines <input type="checkbox"/> Parentheses lines <input type="checkbox"/> bracketing mouth FILLER for Volume: <input type="checkbox"/> Flat cheeks <input type="checkbox"/> Pre-jowl indentation <input type="checkbox"/> Sculpt nose <input type="checkbox"/> Backs of hands <input type="checkbox"/> _____	<input type="checkbox"/> Skin care products <input type="checkbox"/> Skin care advice <input type="checkbox"/> Nutrition for skin wellness <input type="checkbox"/> Eyelash length, fullness, or thickness <input type="checkbox"/> Eyebrow fullness <input type="checkbox"/> Tinting of lashes, brows <input type="checkbox"/> Chemical peels <input type="checkbox"/> Medicated Facials <input type="checkbox"/> Waxing <input type="checkbox"/> Dermaplaning <input type="checkbox"/> _____
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## 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: \_\_\_\_\_

## CANCELLATION POLICY

*Timeless Laser & Skin Care has a 24-hour cancellation policy. Missed appointments not cancelled or rescheduled at least 24 hours in advance will result in a \$50.00 cancellation fee.*