

**PATIENT IN-TAKE FORM**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dermatologist Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**MEDICAL HISTORY:**

**Height:** \_\_\_\_\_’\_\_\_\_\_” **Weight:** \_\_\_\_\_\_\_# Recent weight gain **€Y €N;** Recent weight loss **€Y €N;** if **YES**, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all medical problems for which you have received care**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Please circle if you are taking any of the following medications that cause bruising: blood thinners, Ibuprofen, aspirin, aspirin-

containing medications, vitamin E, krill oil, fish oil, flaxseed oil, omega-3, gingko, ginseng, garlic supplement, glucosamine, or

green tea supplements.

**List all known allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**LIFESTYLE:**

Current smoker? **€Y €N** #Packs/day\_\_\_ #Years\_\_\_\_ Past smoker? **€Y €N** When quit? \_\_\_\_\_#Packs/day\_\_\_\_\_ #Years\_\_\_\_\_ \_\_\_\_\_ pk/yrs

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

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

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

Do you drink \_\_\_ cow \_\_\_ soy \_\_\_ almond milk? How much per day? \_\_\_\_\_\_\_\_\_\_\_\_ Other source of Calcium? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 of whole grains (rice, quinoa) do you eat per day\_\_\_\_\_\_?

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

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

**COSMETIC HISTORY:**

Have you had Botox? **€ Y € N**; Date last injection \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where on your face were you injected?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had fillers? **€ Y € N;** Date last injection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where on your face were you injected?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous laser treatments?**€ Y € N;** When? \_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get cold sores? **€ Y € N**. 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 Hydroquinone in the last month? **€ Y € N**

**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)

* Always burn, never tan (Pale white Caucasian)
* Always burn, sometimes tan (Fair Caucasian)
* Sometimes burn, always tan (Medium-dark Caucasian – Eastern European/Mediterranean)
* Never burn, always tan (Brown Skin – Middle Eastern/Asian/some Latino)
* Moderately pigmented (Dark Brown Skin – African-American/some Latino/Pacific Island)
* Black Skin (African)

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

 Do you wear zinc-based sunscreen on your face, neck, and chest **every day**? **€Y €N**

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

|  |  |  |  |
| --- | --- | --- | --- |
| * Dry Skin
* Brown spots on face, hands, arms, or red/brown blotchiness on neck or chest (circle)
* Rosacea
* Red or blue face veins
* Veins under eyes
* Facial redness
* Red leg veins
* Blue/purple spider leg veins
* Deep blue-green leg veins (do not bulge)
* Cherry angiomas on face

+/or body (circle)* Skin tags
* Sebaceous hyperplasia
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Loose, sagging, crêpy skin on face, neck, arms, or abdomen (circle which)
* Double Chin/ “Turkey waddle”
* Loss of jaw line
* Large pores/Fine lines
* Uneven skin texture
* Dull skin
* Oily skin
* Black- or White-heads
* Pimples
* Cystic acne
* Acne scars
* Red surgical scar
* Wrinkled skin
* Crêpy skin around eyes
* Deep creases around mouth
 | **BOTOX or XEOMIN*** Frown line
* Forehead lines
* Crow’s feet
* Mini brow lift
* Bunny lines
* Toothy Smile

F**ILLER for CREASES:*** Naso-labial folds
* Marionette lines
* Fine lip lines
* Parentheses lines
* bracketing mouth
* Ear lobe creases
* Tear troughs
* Chin crease

**FILLER for VOLUME:*** Thin lips
* Flat cheeks
* Pre-jowl indentation
* Sculpt nose
* Chin
* Back of hands
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Skin care products
* Skin care advice
* Nutrition for skin wellness
* Eyelash length, fullness, or thickness
* Eyebrow fullness
* Tinting of lashes, brows
* Chemical peels
* Medicated Facials
* HydraFacial
* Diamond Glow
* Waxing
* Lash/Brow Tint
* Lash Lift
* Brow Lamination
* Dermaplaning
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

# Physical Appearance Perception

1. Are you worried about how you look? Examples of areas of concern include: your skin (acne, scars, wrinkles, paleness, redness); the shape or size of your nose, mouth, jaw, lips, etc., or defects of your hands, genitals, breasts, or any other body part? **€ Y € N**

**If Yes:** Do you think about your appearance problems a lot and wish you could think about them less? **€ Y € N**

**NOTE: If you answered No to either of the above questions, you are finished with this questionnaire. Otherwise, please continue.**

1. Is your main concern with how you look that you aren’t thin enough or that you might get too fat? **€ Y € N**
2. How has this problem with how you look affected your life?
	1. Has it often upset you a lot? **€ Y € N**
	2. Has it often gotten in the way of doing things with friends, dating, your relationships with people, or your social activities? **€ Y € N**
	3. Has it caused you any problems with school, work, or other activities? **€ Y € N**
	4. Are there things you avoid because of how you look? **€ Y € N**
	5. On an average day, how much time do you usually spend thinking about how you look? (Add up all of the time you spend in total in a day)

**€ Less than 1 hour per day € 1-3 hours per day € More than 3 hours per day**

# 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 $75.00 cancellation fee. 12/2022*