MEDICAL INTAKE FORM

Date: _____

Name: _____Birth Date: _____

Address: _____

City: _____State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

E-Mail Address _____:

Emergency Contact: (Name & Phone) _____

Primary Physician: (Name & Phone) _____

Do we have permission to contact you by phone or leave messages: _____ Yes _____ No

Do we have permission to show your non-identifying photos for educational purposes? _____Yes _____ No

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/Wrinkles
___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