Medical Aesthetics Intake Form

Patient Name _____ Date of Birth _____ Today's Date _____
Address _____ City, State, Zip _____
Home Phone _____ Cell Phone _____
E-Mail _____
(required for specials/events and appointment confirmations)
How did you hear about us? (please be as specific as possible) _____

Medical History

List any non-topical medications you take (hormones, birth control pills, antibiotics, blood pressure, etc.):

_____

_____

List any topical medications you use (Retin-A, other prescribed acne medications, antibiotics etc.):

_____

Have you ever been prescribed Accutane or any other oral retinoid? If so, list dates/duration.

_____

List any medication allergies, skin allergies or sensitivities:

_____

List any health problems or reasons you are under a physician's care:

_____

List any history of skin cancer or family history of skin cancer:

_____

List any skin care problems that you see a physician or aesthetician for:

_____

Have you ever had a cold sore? Yes / No If yes, do you get them often? Yes / No Take meds? Yes / No

Females: Are you pregnant or breastfeeding? Yes / No

Skincare History

Do you have any of the following skin issues?

Fine Lines Deep Wrinkles Skin Laxity Volume Loss Brown Spots Veins
Tone/Texture Concerns Large Pores Acne Redness Dull Skin

Do you have a history of acne or breakouts? Yes / No
Do you only experience acne or breakouts around your menstrual cycle? Yes / No
Would you describe your skin type as: Normal Combination Oily Dry

Do you flush or redden when eating spicy foods, drink alcohol or are in the sun? Yes No
How does your skin react when you are exposed to the sun?

I Always Burn II Usually Burn III Sometimes Burn IV Rarely Burn
V Never Burn (Brown) VI Never Burn (Black)

Do you wear sunscreen daily? Yes No If yes, what is the SPF of your sunscreen? _____
Have you had any unprotected natural sun or tanning bed exposure in the last 6 weeks? Yes No
Do you currently use skincare products on a daily basis? Yes No

What skincare products are you currently using? Brand and Type (Vit C, HA, Retinol)

_____ _____
_____ _____

Have you ever had the following?	**What type and when?**
Facial, HydraFacial	_____
Chemical Peel	_____
Dermaplaning/Micro-Needling	_____
Waxing/Microblade/Lashes	_____
Neurotoxins Botox / Dysport / Xeomin	_____
Filler (Sculptra, Juvederm, Voluma, etc.)	_____
Laser Treatment (list year and type)	_____
Body Contouring (CoolSculpting, RadioFrequency)	_____
Cosmetic Surgery (list year and type)	_____

Are you interested in learning more about any of the following treatments that we offer?

Facials Chemical Peels Dermaplaning HydraFacial Microneedling
Botox Fillers Aquagold Kybella PDO Threads PRP
Laser Hair Removal IPL / BBL HALO MOXI MORPHEUS VIVACE
Skin Tightening CoolTone CoolSculpting Butt/Breast Lift
Sexual Rejuvenation Hair Restoration O-Shot/P-Shot Sauna
Ozone Hormone Treatment Medical Weight Loss Wellness Medicine IV Therapy
Skin Care Products Supplements

What top concerns would you like to address today?

1._____

2._____

3._____

I have also been given, read and understand the 'aNu Patient Policy and Procedures'.

_____ _____ _____
Patient's Name (Please Print) Patient's Signature Date