



## Medical Aesthetics Intake Form

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Carrier \_\_\_\_\_  
E-Mail (required for specials/events and appointment confirmations) \_\_\_\_\_  
How did you hear about us? (list name of person if referred) \_\_\_\_\_

### Medical History

List any any oral medications you take (oral hormones, birth control pills, antibiotics, hypertension, 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 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

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  Tone/Texture  
 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, get angry 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? \_\_\_\_\_

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?

\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had?**

**If yes, when was your last treatment?**

Facial

\_\_\_\_\_

Chemical Peel (Lactic, Salicylic, Glycolic, TCA, Other)

\_\_\_\_\_

Microdermabrasion/Dermaplaning/Micro-needling

\_\_\_\_\_

Waxing/Microblade/Lashes

\_\_\_\_\_

Botox / Dysport / Xeomin

\_\_\_\_\_

Filler (Restylane, Radiesse, Juvederm, Voluma, etc.)

\_\_\_\_\_

Laser Treatment (list date and type)

\_\_\_\_\_

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  Lash Lift  Microblading Microdermabrasion

Microneedling  Waxing Skin Care Products

Kybella Botox Fillers

Laser Hair Removal Laser Skin Tightening Brown/Red pigment treatments

Urine Incontinence Treatment Feminine Rejuvenation O-Shot

Hormone Treatment Medical Weight Loss Wellness Medicine

**What issues would you like to address today?**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Please be advised that our cancellation policy states that all no shows and late cancellations (under 24 hours) for medical aesthetic appointments will be charged \$25. If you need to cancel or reschedule, we do require 24 hours notice so another patient can use the appointment time. We are a small company and strive to provide the best personal care possible by not over booking. Thank you for your understanding and for choosing aNu.**

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date