Date:____________________

Medical Intake Form

Name:____ Birth Date:____________________

Address: ____

City:____ State:__________ Zip:_________________

Cell Phone:______________________________ Work Phone:_______________________________

E-Mail Address:____

Emergency Contact: (Name & Phone)____

Primary Physician: ____

Do we have permission to contact you by phone or leave messages: _____Yes _____No

Preferred method of contact: _____ Phone _____Text _____E-Mail

Do we have permission to show your 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 ___ Body Acne ___Broken Blood Vessels

___Bumps on back of arms ___Cellulite ___Cysts/Nodules

___Dehydrated Skin ___Dull Complexion ___Excessive Facial Hair

___Facial Veins ___Fine Lines/Wrinkles ___Frequent Breakouts

___Large Pores ___Loss of Lashes/Brows ___Melasma/Brown Spots/Patches

___Oily Skin ___Redness ___Rough/Uneven Skin Texture

___Rosacea ___Sagging Skin ___Sun Damage

___Under Eye Puffiness/Dark Circles ___Other:_____________________________________

____

How would you describe your skin? ___Oily ___Dry ___Combination ___Sensitive

How would you describe your stress level? ____Little ____Moderate ____High ____Severe

Do you feel your stress level may be affecting the health of your skin? _____Yes _____No

Are you in good health overall? _____Yes _____No Concerns:_____________________________