PATIENT IN-TAKE FORM

Name: _____ **Date:** _____

Address: _____

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	☐ Loose, sagging, crêpy skin on face, neck, arms, or abdomen (circle which)	**BOTOX or XEOMIN**	☐ Skin care products
☐ Brown spots on face, hands, arms, or red/brown blotchiness on neck or chest (circle)	☐ Double Chin/ "Turkey waddle"	☐ Frown line	☐ Skin care advice
☐ Rosacea	☐ Loss of jaw line	☐ Forehead lines	☐ Nutrition for skin wellness
☐ Red or blue face veins	☐ Large pores/Fine lines	☐ Crow's feet	☐ Eyelash length, fullness, or thickness
☐ Veins under eyes	☐ Uneven skin texture	☐ Mini brow lift	☐ Eyebrow fullness
☐ Facial redness	☐ Dull skin	☐ Bunny lines	☐ Tinting of lashes, brows
☐ Red leg veins	☐ Oily skin	☐ Toothy Smile	☐ Chemical peels
☐ Blue/purple spider leg veins	☐ Black- or White-heads	**FILLER for CREASES:**	☐ Medicated Facials
☐ Deep blue-green leg veins (do not bulge)	☐ Pimples	☐ Naso-labial folds	☐ HydraFacial
☐ Cherry angiomas on face +/or body (circle)	☐ Cystic acne	☐ Marionette lines	☐ Diamond Glow
☐ Skin tags	☐ Acne scars	☐ Fine lip lines	☐ Waxing
☐ Sebaceous hyperplasia	☐ Red surgical scar	☐ Parentheses lines	☐ Lash/Brow Tint
☐ Other: _____	☐ Wrinkled skin	☐ bracketing mouth	☐ Lash Lift
	☐ Crêpy skin around eyes	☐ Ear lobe creases	☐ Brow Lamination
	☐ Deep creases around mouth	☐ Tear troughs	☐ Dermaplaning
		☐ Chin crease	☐ Other:_____
		FILLER for VOLUME:	
		☐ Thin lips	
		☐ Flat cheeks	
		☐ Pre-jowl indentation	
		☐ Sculpt nose	
		☐ Chin	
		☐ Back of hands	
		☐ 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.
2. Is your main concern with how you look that you aren't thin enough or that you might get too fat? ☐ **Y** ☐ **N**
3. How has this problem with how you look affected your life?
   a. Has it often upset you a lot? ☐ **Y** ☐ **N**
   b. Has it often gotten in the way of doing things with friends, dating, your relationships with people, or your social activities? ☐ **Y** ☐ **N**
   c. Has it caused you any problems with school, work, or other activities? ☐ **Y** ☐ **N**
   d. Are there things you avoid because of how you look? ☐ **Y** ☐ **N**
   e. 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.* *4/2023*