



Patient Information and Medical History

In order to provide you with the most appropriate treatment, please complete the following. All information is strictly confidential.

Personal History

Name: _____ Date: _____

Name of Guardian if under 18 years old: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Age: _____ Date of Birth: _____

To receive our monthly specials, please provide email: _____

Employer: _____ Occupation: _____

Pharmacy Name: _____ Pharmacy Tel.: _____

How did you hear about us? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Internet | <input type="checkbox"/> Miss Florida Program |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Magazine (Which One?) <input checked="" type="checkbox"/> _____ | |
| <input type="checkbox"/> Friend Referral (Who can we thank?) <input checked="" type="checkbox"/> _____ | |

If we need to contact you regarding your treatments, please identify the way we can reach you:

- Phone Email Text

If Phone: Is it okay to leave a detailed message? Yes No

If we are unable to speak directly to you, please list spouse, family member or friend, if any, with whom we can speak with regarding your appointments or other personal heal information:

Name: _____ Phone: _____ Relationship: _____

Patient Initials _____

Whom should we contact in the event of an emergency?

Name: _____ Phone: _____ Relationship: _____

Medical Insurance

Name of insurance company: _____

Phone Number: _____ Group Number: _____ Policy Number: _____

Are you pregnant, possibly pregnant or considering pregnancy in the near future? Yes No
Are you lactating? Yes No

Current Medical Conditions *(Check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Any Implanted Devices | <input type="checkbox"/> Keloid/Raised Scars |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Lupus/Auto Immune |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Melasma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes Simplex |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pre-Cancerous/Cancerous Skin Lesions |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud Phenomenon |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Acne Rosacea/Rosacea |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Seizure Disorder |

Current Medications *(Are you taking any of the following)*

- | | |
|--|--|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Thyroid Medication |
| <input type="checkbox"/> Aldactone/Spironlactone | <input type="checkbox"/> Oral Birth Control |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Hydroquinone | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Minoxidill | <input type="checkbox"/> DHEA |
| <input type="checkbox"/> Nicotine | <input type="checkbox"/> NSAIDS./Aspirin |
| <input type="checkbox"/> Testosterone | <input type="checkbox"/> Prednisone/Steroids |
| <input type="checkbox"/> Tetracyclines | <input type="checkbox"/> Retin-A/Tretinoin |
| <input type="checkbox"/> Other: _____ | |

Please list any other conditions for which you are or have been under a physician's care:

Do you have a family history of female blood relatives with excess hair? Yes No

If you are between the ages of 35-58, are you going through pre-menopause/menopause? Yes No

Patient Initials _____

Other hair removal methods used:

What method was used? _____ How often was it used? _____

How long have you used this method? _____ When did you last use this method? _____

Please note: We do charge a \$20 fee for missed appointments (excluding those which require deposits). Please initial: _____

I have received the HIPPA privacy notice. Please initial: _____

I have answered these questions truthfully and will notify About Skin, LLC of any changes in medications or my physical conditions. I have received or viewed online a copy of the About Skin, LLC Privacy Policy. If I have given permission to leave detailed messages, fax or email information regarding my treatment and/or discuss my medical care with specific family and/or friends, I understand that I am granting a waiver of my privacy rights under HIPAA. If I decide to change these instructions, I will notify About Skin, LLC in writing as soon as possible. If I have given my e-mail address above, I understand that my email is not privacy protected.

Patient Signature

Date

Esthetician Signature

Date