Fab Skin Center

Client Intake Form

Patient Name (please print): _____ Age:_____

Date of Birth:_____ Address:_____

City:_____ State:_____

Zip Code:_____ Email: _____

Home/Work/Cell Phone: (____)_____

Who referred you?_____

Emergency Contact / Phone:

_____

Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, weight loss medications, Coumadin or any blood thinning medication, prescription eye drops, steroids) Medication(s)/Naturopathic/Health Food Supplements Amount Frequency List all ALLERGIES including LATEX:

_____

Are you a smoker? YES/ NO Ex-smoker: YES/ NO

Do you drink alcohol? _____

Caffeine Intake_____

Please circle all the following medical conditions you now have or have had in the past.

Thyroid Disease / Cancer / Bleeding Tendency / Diabetes / Blood Transfusions / Glaucoma / Lung Disease / TB / Asthma or Wheezing / Emphysema / Neurological Disorders / Irregular Heart Beat / Chest Pain / Heart Disease / High Blood Pressure / Heart Attack / Stroke / Epilepsy / Heartburn / Intestinal Ulcers or Bleeding / Rheumatoid Arthritis / Scleroderma / Lupus / MS / Myasthenia Gravis / Raynaud's Syndrome / Porphyria / Depression / Mental Illness / Drug or Alcohol Addiction / Hepatitis B / Hepatitis C / HIV / Any other serious illness or injury.

Medical and Skin Care Intake Form

Are you pregnant or lactating? YES/NO

Do you have a history of developing keloids (raised scars)? YES/NO

Have you ever been diagnosed with Vitiligo (pigment loss in the skin)? YES/NO

Have you ever seen a dermatologist for your skin? If so, for what?_____

Do you or have you used any topical medications? If so, which?_____

Have you ever had unusual reactions to topical anesthetics (numbing cream)? YES/NO

Do you use any form of Retin-A, Glycolic Acid or Salicylic Acid? YES/NO

Have you ever been on Accutane? If so, how long ago? _____

Have you ever had Botox™ or Dermal Filler injections? If so, how long ago?_____

Have you ever had a bad reaction to any skin care products? YES/NO

Have you ever had a chemical peel? If so, did you have any adverse reactions? _____

Do you use a sunscreen? YES/NO

Do you wax or use depilatories on your face? If so, when was the last time?_____

Do you have a history of atypical moles, melanoma or skin cancer in yourself or family?

Does your skin get oily a few hours after cleansing? YES/NO

Do you have a history of acne or periodic outbreaks?

Which of the following best describes your skin type? (Please circle one type number) I Always burns, never tans II Always burns, sometimes tans III Sometimes burns, always tans IV Rarely burns, always tans V Brown, moderately pigmented skin VI Black skin List all surgeries that you have had (include plastic surgery)

Date I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. Patient Name:

_____ Signature: _____ Date: _____