AE SKIN

Professional Medical Spa
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16311 Ventura Bl. Suite 845
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(818) 835 - 1833
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PATIENT INFORMATION AND MEDICAL HISTORY

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

Personal Information

Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ Gender □ Male □ Female

Home Address _____

City _____ State _____ Zip Code _____

Primary Phone (_____) _____ – _____ Secondary Phone (_____) _____ – _____

Occupation _____

E-mail Address _____

Would you like to receive our exclusive specials via e-mail? We do not share your e-mail address. □ Yes □ No

Emergency Contact Name and Phone _____

How were you referred to us? _____

Dermatololgic History

Are you currently under the care of a dermatologist? □ Yes □ No

If yes, for what: _____

Name of dermatologist: _____

Which of the following best describes your skin type?

□ I Very Fair: Always burns, Never tans

□ II Fair: Burns easily, Sometimes Tans

□ III Light Olive: Rarely burns, Usually tans

□ IV Olive: Rarely burns, Always tans

□ V Brown: Rarely burns, Tans profusely

□ VI Dark Brown: Never burns, Tans profusely

Have you ever had skin cancer? □ Yes □ No

If yes, what kind? _____

Has anyone in your family ever had skin cancer? □ Yes □ No

If yes, what kind? _____

Do you regularly sun bathe or use tanning salons? □ Yes □ No

If yes, how often? _____

What skin care products have you used in the past? _____

_____

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? □ Yes □ No

Have you had any recent tanning or sun exposure that changed the color of your skin? □ Yes □ No

Have you recently used any self-tanning lotions or treatments? □ Yes □ No

Do you form thick or raised scars from cuts or burns? □ Yes □ No

Have you ever had laser hair removal? □ Yes □ No

Have you ever had Botox® injections? □ Yes □ No

Have you ever had dermal filler injections (for example, Juvéderm, Restylane)? □ Yes □ No

Have you used any of the following hair removal methods in the past six weeks (check all that apply)?

□ Shaving □ Electrolysis □ Tweezing □ Depilatories

□ Waxing □ Plucking □ Stringing

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? □ Yes □ No

If yes, please describe. _____

Medical History

Are you currently under the care of a physician? □ Yes □ No

If yes, for what: _____

Do you have a pacemaker? □ Yes □ No

Do you have any of the following medical conditions? (Please check all that apply)

□ Arthritis	□ Frequent cold sores	□ Any active infection	□ Any neurological disorder
□ Asthma	□ Heart Condition	□ Bleeding disorder	□ AML (Lou Gehrig's disease)
□ Cancer	□ Hepatitis	□ HIV/AIDS	□ Lambert-Eaton syndrome
□ Diabetes	□ High blood pressure	□ Hormone imbalance	□ Myasethenia gravis
□ Eczema	□ Keloid scarring	□ Skin disease/Skin lesions	□ Parkinson's disease
□ Glaucoma	□ Kidney disease	□ Thyroid imbalance	□ Seizure disorder
□ Hay fever	□ Liver disease	□ Psychiatric disorder	
□ Herpes	□ Autoimmune disease		

Do you have any other health problems or medical conditions? Please list:

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)

□ Food □ Aspirin □ Hydrocortisone □ Hydroquinone or skin bleaching agents

□ Latex □ Lidocaine □ Animal Protein □ Others**:** _____

Have you ever been diagnosed with body dysmorphic disorder that you are aware of? □ Yes □ No

Medications

What oral prescription medications are you presently taking? □ Birth control pills □ Hormones

□ Others (It is required that you list all of them): _____

_____

Are you currently taking any aminoglycoside antibiotics: amikacin (Amikin®), gentamicin (Garamycin®), kanamycin (Kantrex®), neomycin (Mycifradin®), netlimicin (Netromycin®), paromomycin (Humatin®), streptomycin, or tobramycin (TOBI solution®, TobraDex®, Nebcin®)? □ Yes □ No

Are you currently taking D-penicillamine? □ Yes □ No

Are you currently taking any anti-malarial medications? □ Yes □ No

Are you currently taking any immunosuppressive medications? □ Yes □ No

Have you ever taken isotretinoin (Accutane)? □ Yes □ No

If yes, when was your last dose? _____

Are you taking any blood-thinning medications such as aspirin, Coumadin (warfarin), ibuprofen or motrin, non-steroidal anti-inflammatory drugs, or products containing Ginko biloba? □ Yes □ No

What antibiotics do you use to treat infections? _____

Do you take any medications for glaucoma or increased intra-ocular pressure? □ Yes □ No

If yes, which ones? _____

Do you take any medications for heart conditions? □ Yes □ No

If yes, which ones? _____

Are you on any mood altering or anti-depression medication? □ Yes □ No

If yes, which ones? _____

What topical medications or creams are you currently using? □ Retin-A , □ Others (Please list):

_____

What herbal supplements do you use regularly? _____

Surgical History

Have you ever had surgery? ☐ Yes ☐ No

If yes, please list all surgeries: _____

_____

Obstetrical and Gynecological History

For female patients only.

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Are you using contraception (birth control pills, condoms, IUD, abstinence)? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No

When was your last menstrual period? _____

Social History

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____

How long have you been smoking for? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type and how much? _____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____

For patients under the age of 18, parental signature is required below.

Parent Name: _____

Signature: _____ Date: _____

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Aesthetic Questionnaire

Name: _____

1. Which of the following concerns do you have regarding your skin? Please check all that apply.

□ Fine lines
□ Deep wrinkles
□ Acne
□ Texture
□ Acne Scars
□ Dark spots / discoloration
□ Redness
□ Broken blood vessels
□ Enlarged pores
□ Other: _____

2a. Do you apply sunscreen every day?

□ Yes
□ No

2b. What is the SPF value of the sunscreen you use? _____

3. Which of the following treatments have you had in the past? Please check all that apply.

□ Botox / Dysport / Xeomin
□ Fillers (Juvéderm, Restylane, Radiesse)
□ IPL Photofacial
□ Laser Hair Removal
□ Resurfacing / Fraxel
□ Skin Tightening (Thermage, Titan, etc.)
□ Chemical Peels
□ Leg Vein Treatments

4. Which of the following treatments are you interested in? Please check all that apply.

□ Botox / Dysport / Xeomin
□ Fillers (Juvéderm, Restylane, Radiesse)
□ IPL Photofacial
□ Laser Hair Removal
□ Resurfacing / Fraxel
□ Skin Tightening (Thermage, Titan, etc.)
□ Chemical Peels
□ Leg Vein Treatments

5. How much younger / fresher would you like to look?

□ 0 – 5 years
□ 5 – 10 years
□ > 10 years

6. How much time off can you devote to your enhancement for recovery?

□ Less than 3 days
□ 3 – 7 days
□ 1 – 3 weeks

7. How much money would you like to invest to achieve your goals?

□ < $ 500
□ $ 500 - $ 1,000
□ $ 1,000 - $ 2,000
□ $ 2,000 - $ 5,000
□ > $ 5,000

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Cancellation Policy

At A E Skin, patient satisfaction is a top priority and we strive to accommodate all of our patients. In an effort to provide you with the best patient care and to keep our practice running efficiently, we are instituting a new policy effective July 1, 2014. A $50.00 cancellation/no show fee will be charged for any appointment that is not cancelled within 24 hours of the scheduled time. This is out of respect for our practice and other patients' time. Thank you for your cooperation.

Please sign below indicating that:

- You understand the policy,
- You will provide A E Skin with 24 hours notice ahead of any scheduled appointment, and
- If you do not cancel an appointment within 24 hours of the scheduled time you agree to pay this fee.

Patient Name (print)	Patient Signature	Date

Witness Name (print)	Witness Signature	Date