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**Esthetic New Patient Questionnaire**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_/\_\_/\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications- Are you currently taking/ using any of the following?**

|  |  |
| --- | --- |
| Accutane (Isotretinoin) | YES NO |
| Blood Thinners | YES NO |
| Aspirin | YES NO |
| Topical Retinoids (tretinoin, retin-a, differin, retinaldehyde, adapalene, retinol, etc.) | YES NO |
| Hydroquinoine | YES NO |
| Photosensitizing Medications | YES NO |
| Other: | YES NO |

**Allergies- Are you allergic to any of the following?**

|  |  |
| --- | --- |
| Sulfa | YES NO |
| Seafood/ Fish | YES NO |
| Aspirin | YES NO |
| Fruit | YES NO |
| Soy | YES NO |
| Other: | YES NO |
| □ NO KNOWN ALLERGIES |  |

**Other**

|  |  |
| --- | --- |
| Are you pregnant or nursing? | YES NO |
| Do you wear contacts? | YES NO |
| Metal implements in body? | YES NO |
| Have you had any:  Facial Waxing, Chemical Peels, Microdermabrasion, Laser Treatment, Botox, Filler, Other Injectables | YES NO  If yes, when? Please detail: |
| Sun exposure in the last 7 days or frequently exposed | YES NO |
| Eczema or Psoriasis? | YES NO |
| Are you prone to cold sores? Any open wounds? | YES NO |
| Diabetic? | YES NO |
| Epileptic? | YES NO |
| Hepatitis? | YES (A B C) NO |
| HIV+/ Possibly Exposed? | YES NO |
| Other (describe): | YES NO |

**What skin care products are you currently using at home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What are you concerns regarding your skin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[NOTES FOR OFFICE USE ONLY] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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By signing below patient certifies that questions have been answered fully and to the best of their knowledge. Provider has made no guarantee implied or expressed as to outcome of treatment. Patient releases provider of all liability.

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Documented by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**