Advanced Aesthetic Dermatology

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New Patient Information

Name ______________________ DOB __________ Sex __________

Street Address ______________________ City/State __________ Zip __________

Home Phone __________ Cell Phone __________ Email Address __________

___Yes___No ______________________________________________

Insurance Subscriber Name Subscriber DOB Relationship

Describe Main Concern: ______________________________________________

How do you want to improve or change your skin? ______________________________

**Check all that apply to you**

__Flushing __Blushing __Redness __Uneven Pigment __Fine Lines
__Broken Vessels __Pimples __Unwanted Hair __Acne Scarring __Skin Texture

Current Age____ Age when symptoms began____ Past Treatment ______________________

HOW WERE YOU REFFERED TO THIS OFFICE? ______________________________

Current Medications (include topical, oral medications, vitamins/supplements) ______________________

List all allergies: ______________________________________________

My general health is: (circle one) **VERY GOOD** **GOOD** **FAIR** **POOR**

**Do you have any history of the following:**

YES NO Herpes, cold sores, fever blisters or facial warts
YES NO Taking birth control pills or history
YES NO Drug reactions: Allergic reactions to Lidocaine, Novacaine, or local anesthetics or Latex skin allergies
YES NO Accutane or Radiation therapy for acne. When? ______________________
YES NO Vitiligo or loss of pigment of the skin
YES NO Allergies: Hay fever, Asthma, Eczema or Hives
YES NO Chronic illness: Tuberculosis, Fungus disease, Glaucoma, Cataracts, Ulcers, Psoriasis, Heart disease, Cancer, Hepatitis, Diabetes, High blood pressure, Bleeding problems, recurrent infections or poor healing, Skin cancer
YES NO Allergy to cold, Raynaud's disease, Lupus, or auto-inmune disorder
YES NO **For Females:** are you currently pregnant or planning a pregnancy
YES NO Have you been hospitalized, explain: ______________________________
YES NO Have/Are you using Retin-A How long______ (circle one) **0.1%** **.05%** **.025%**

What type of cleanser do you use? (circle one) **SOAP** **GEL** **CREAM** **MILKY** **OTHER**

Do you use (circle all that apply) **TONER** **ASTRINGENT** **FACIAL SCRUBS** **BUFFER** **LOOFAH** **HOT WATER** **HOT WAX** **ELECTROLYSIS**

List all other products ______________________________________________

Does you skin ever feel: **TIGHT** **FLAKEY** **SHINEY** **BROKEN OUT**

How often do you use Sun Screen ______________________ List SPF and Type ______________

Patient Signature ______________________________________________ DATE ______________