Name: ____

Address: _________________________ **City:** ___________________ **State:** ________

Date of Birth: ________________________ **Sex:** ______________________________

Email Address: ____

Home Phone: _______________________ **Cell Phone:** __________________________

How did you hear about us?

- ☐ The Paducah Sun
- ☐ Radio
- ☐ The Yellow Pages
- ☐ The Wright Pages
- ☐ Bridal Expo
- ☐ Real Women's Expo
- ☐ Baby Fair
- ☐ Magazine ______________________
- ☐ Friend or Family Member (Please tell us so we may thank them!) ______________________
- ☐ Other ____

Health History:

Have you seen a Dermatologist in the past year? Yes ____ No ____
If yes, list Dermatologist name and reason for visit ____
____

Are you presently under a Physician's care? Yes ____ No ____
If yes, list Physician's name and reason for visit ____
____

Are you currently taking any medications? Yes ____ No ____ if yes, please list ____________________
____

Please circle the following conditions you have or have experienced:

Hypertension	Cold Sores	Anemia	Cancer	seizures	headaches	hepatitis
Metal plate	hernia	lupus	thyroid disorders		asthma	tooth fillings
Diabetes	stroke	contact lenses	claustrophobia		varicose veins	epilepsy
High/low blood pressure						

Allergies:

Have you ever had an allergic reaction to any of the following:
Aspirin or Salicylates Yes ____ No ____
Milk Yes ____ No _____

Apples Yes ____ No ____
Citrus Yes ____ No ____
Grapes Yes____ No ____
Ingredients in skincare products Yes ____ No ____
Fish, marine or iodine allergies Yes ____ No ____
Latex Yes ____ No ____
If you checked yes to any of the above, please explain: ____
____
Please list any known allergies: ____
____

Have you ever had Herpes Simplex? Yes ____ No ____
Are you being treated for Hepatitis? Yes ____ No _____

Skincare History:

Are you currently having skin treatments? Yes ____ No ____
If yes, what type of treatments? ____
____

Please check if you are presently using or have used any of the following:

_______ Benzoyl Peroxide
_______ Glycolic Acid
_______ Lactic Acid
_______ Resorcinol
_______ Salicylic Acid
_______ Sulfur
_______ Vitamin A
_______ Vitamin C
_______ Hydrocortisone
_______ Hydroquinone

Do you have or have had any of the following in the last 14 days?

_______ Facial Cosmetic Surgery
_______ Botox injections
_______ Collagen Injections
_______ Fillers
_______Light Treatments
_______ Laser Resurfacing
_______ Microdermabrasion
_______ Chemical Exfoliation
_______ Extractions
_______Permanent Cosmetics
_______Waxing
_______ Laser Hair Removal
_______Hair Treatments (perm, color, etc.)

What skincare products are you currently using at home?

Cleanser ________________________
Toner __________________________
Moisturizer ______________________
SPF ____________________________
Vitamin C _______________________
Exfoliants/Scrubs _________________
Specialty Products _________________
Mask __________________________

Do you feel as if your skin is sensitive? Yes ______ No ______

Please check if you are presently experiencing or have experienced any of the following:

_______ Skin Cancer
_______ Dermatitis
_______ Keloid Scarring
_______ Acne
_______ Rosacea
_______ Broken Capillaries
_______Treatment Reactions
_______Hypopigmentation
_______ Hyperpigmantatin

Prescriptions Products:

_______ Tretinoin (Retin A, Retin-A Micro, Renova, Avita)
_______ Adepalene (Differin)
_______ Azelaic Acid (Azele, Finacea)
_______ Tazarotene (Tazorac)
_______ Isotretinoin (Accutane)
_______ Triluma
_______ Metrogel

Any other topical antibiotics: ____

What skin conditions do you want to improve?

_______ Acne and/or Breakouts
_______ Facial Scarring
_______ Hyperpigmentation (freckles, age spots)
_______ Hypopigmentation
_______ Enlarged Pores
_______ Fine Lines and Wrinkles
_______ Rosacea
_______ Uneven Tone
_______ Uneven Texture
_______ Dehydration
_______ Oily
_______ Sun Damage

Other: ____
____

Is there any other necessary information your skincare specialists should know before beginning your treatment? Yes _______ No _______

If yes, please explain ____
____
____

Patient Policies

We are pleased to have you as our client. These policies have been established so that we can give you the best care possible.

- ❖ If you are more than 15 minutes late for your scheduled appointment, you will be asked to reschedule.
- ❖ We ask that you PLEASE give our office 24 hours notice of cancellation unless it is an emergency situation.

I have acknowledged that all of the information provided by me is true and correct to the best of my knowledge.

I understand that some skin conditions may require more than one treatment and the use of home care products to achieve the result desired. Results cannot be guaranteed due to individual skin types and conditions.

I understand that if any of the information pertaining to the above questionnaire is to change I will notify Total Rejuvenation before my next appointment.

Client Signature: ___________________________________ **Date:** ____________________