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Patient Intake Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_/\_\_\_\_/\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ I give permission to Allure Skin and Laser to send me occasional email newsletters and promotions.

How did you hear about us? (Please fill in account name or check)

Instagram : \_\_\_\_ Friend/Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Google: \_\_\_\_ Facebook : \_\_\_\_ Other (list): \_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current daily skin care regimen?

AM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Procedures: Which of the following have you had in the past? (Please check all that apply)

\_\_\_Botox \_\_\_ Tattoo Removal

\_\_\_Jeuveau \_\_\_ Laser Hair Removal (Location\_\_\_\_\_\_\_\_\_)

\_\_\_Injectable Fillers (ie Juvederm, Vollure, Voluma etc) \_\_\_ Permanent Makeup or Microblading

\_\_\_ Facials \_\_\_ Laser/Skin Resurfacing

\_\_\_ Microdermabrasion \_\_\_ Photofacial/ IPL

\_\_\_ Chemical Peels \_\_\_ Skin Tightening

\_\_\_ Microneedling \_\_\_Waxing or Threading

\_\_\_ Microneedling with PRP \_\_\_ Ultherapy

\_\_\_ Cellulite Reduction/ Body Contouring

\_\_\_ Electrolysis

\_\_\_ Facial Cosmetic Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical History

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Medications: (Including Topical Medications like Allergies and Reaction: (Including Latex, Medications,

Rein-A, Tretinoin, etc) food, if none, write “none” )

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Y N Are you nursing? Y N Are you planning on becoming pregnant? Y N

Are you currently taking ACCUTANE, or have you taken ACCUTANE in the last 6 months? Y N

Do you use tanning beds? Y N Do you wear sunscreen daily? Y N

Any dental work/cleaning in the last 2 weeks, or an upcoming appointment in the next 2 weeks? Y N

Personal Medical History: (Please check all that apply)

\_\_\_ Anemia \_\_\_ Copper IUD \_\_\_Keloid Scars

\_\_\_Autoimmune Disease \_\_\_Diabetes \_\_\_ Lupus

\_\_\_Bleeding Disorder \_\_\_Fibromyalgia \_\_\_ Metal Implants

\_\_\_ Blood Clots \_\_\_ Heart Disease \_\_\_ Pacemaker

\_\_\_ Cancer \_\_\_ Hepatitis B or C \_\_\_ Raynaud’s Disease

\_\_\_ Cochlear Implant \_\_\_ Herpes Simplex \_\_\_ Seizures

\_\_\_ Colitis \_\_\_ High Blood Pressure \_\_\_ Stroke

\_\_\_ Cold Sores \_\_\_ HIV / AIDS \_\_\_ Thyroid Disorder

\_\_\_ Connective Tissue Disorder \_\_\_ Hysterectomy \_\_\_ Valley Fever

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Skin History: (Please check all that apply)

\_\_\_Undiagnosed Skin Lesions \_\_\_ Psoriasis \_\_\_ Actinic Keratosis

\_\_\_ Melasma/ “Pregnancy Mask” \_\_\_ Shingles \_\_\_ Eczema

\_\_\_ Pigment Disorder (ie Vitiligo)

\_\_\_ Skin Cancer (Melanoma, Basal Cell Carcinoma, Squamos Cell Carcinoma)

Previous Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date