CENTER FOR REGENERATIVE & AESTHETIC WELLNESS

# New Patient Information – Aesthetic and Wellness

| Patient Information | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | | | Middle Initial: |
| Prefers to be called: | | | Ethnic Background: | | |
| Date of Birth: | Age: | Sex: ☐ Male ☐ Female | Occupation: | | |
| Street Address: | | City: | State: | Zip Code: | |
| E-mail Address: | | | Mobile Phone: | | |
| Emergency Contact: | | Relationship: | Phone: | | |
| How did you hear about us? ☐ Google ☐ Social Media ☐ Friend/Family ☐ Existing Patient ☐ Other | | | | | |

| Communication Preferences | | |
|---|---|---|
| May we send appointment reminders by text? | ☐ Yes | ☐ No |
| May we send promotional, aesthetic, wellness, and educational information by text? | ☐ Yes | ☐ No |
| May we send promotional, aesthetic, wellness, and educational information by email? | ☐ Yes | ☐ No |
| **If I choose to receive communications by email, I understand that email is not a secure method of communication and accept the associated risks.* | | |

**Treatment Interests**

*Which services are you interested in today? (Check all that apply)*

| Injectables | Facials | Laser/Energy |
|---|---|---|
| ☐ Botox | ☐ Customized Facial | ☐ Emsculpt Neo |
| ☐ Dermal Fillers | ☐ Salt Facial | ☐ Exomind |
| ☐ Lip Fillers | ☐ Chemical Peel | ☐ Emsella |
| ☐ Full Face Augmentation | ☐ Microneedling | ☐ Laser Hair Removal |
| ☐ Platelet-Rich Plasma (PRP) | ☐ Dermaplaning | ☐ Venus Versa Tribella 3-in-1 Treatment |
| ☐ Platelet-Rich Fibrin (PRF) | | ☐ IPL Photofacial |
| ☐ PRP Hair Restoration | | ☐ Skin Tightening |
| | | ☐ Nano-Fractional Resurfacing |

**Treatment Goals & Concerns**

*Please indicate the areas you would like evaluated/discussed. (Check all that apply)*

| Injectables | Facials/Laser/Energy | |
|---|---|---|
| ☐ Forehead Lines | ☐ Acne / Breakouts | ☐ Melasma |
| ☐ Frown Lines ("11's") | ☐ Blackheads | ☐ Rosacea / Redness |
| ☐ Crow's Feet (corner of eyes) | ☐ Whiteheads | ☐ Unwanted Hair |
| ☐ Bunny Lines (sides of the nose) | ☐ Excessive Oil / Shine | ☐ Skin Tightening |
| ☐ Lip Enhancement | ☐ Dull/Dry/Dehydrated Skin | ☐ Sensitivity |
| ☐ Nasolabial Folds (smile lines) | ☐ Laxity | ☐ Fat Reduction |
| ☐ Marionette (corners of the mouth) | ☐ Texture | ☐ Muscle Building / Toning |
| ☐ Jawline | ☐ Hyperpigmentation | ☐ Stress / Anxiety / Depression |
| ☐ Chin | ☐ Uneven tone | ☐ Sexual Wellness |
| ☐ Nasolabial Folds (smile lines) | ☐ Scarring | ☐ Urinary Incontinence / Leakage |
| ☐ Full Face Augmentation | ☐ Other | ☐ Sexual Wellness |

| For Female Patients | | |
|---|---|---|
| Are you currently pregnant? | ☐ Yes | ☐ No |
| Are you actively trying to become pregnant? | ☐ Yes | ☐ No |

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| Which of the following describes your skin type? |
|---|
| ☐ **I** Porcelain Complexion<br>Always burns easily, never tans |
| ☐ **II** Light Complexion<br>Always burns |
| ☐ **III** Light/ Matte Complexion<br>Burns moderately, tans gradually |
| ☐ **IV** Matte Complexion<br>Seldom burns, always tans well |
| ☐ **V** Brown Complexion<br>Rarely burns, deep tan |
| ☐ **VI** Black Complexion<br>Never burns, deeply pigmented |

| Have you had any cosmetic treatments/procedures? | | | |
|---|---|---|---|
| ☐ Facial | ☐ Botox/Injection/Fillers | | |
| ☐ Microdermabrasion | ☐ Photo Facial/IPL | | |
| ☐ Chemical Peel | ☐ Facial Surgery | | |
| ☐ Laser Hair Removal | ☐ Plastic Surgery | | |
| ☐ Microneedling | | | |
| ☐ Other | | | |
| **Were you satisfied with the results?** | | ☐ Yes | ☐ No |
| **Any previous complications?** | | ☐ Yes | ☐ No |
| If yes, please describe: | | | |

| Current Skincare Regimen<br>Please write the brand behind every box you select. | | |
|---|---|---|
| ☐ Cleanser | ☐ Toner | ☐ Exfoliant/Scrub |
| ☐ Mask | ☐ Serum | ☐ Moisturizer |
| ☐ Eye product | ☐ SPF | ☐ Night Cream |
| ☐ Treatment | ☐ Acne Product | ☐ Makeup |
| ☐ Other | | |

| Skin Treatment Considerations | | |
|---|---|---|
| Do you use Retin-A, Renova, or Retinol/vitamin A derivative products? | ☐ Yes | ☐ No |
| Have you used alpha-hydroxy or glycolic acid products in the last 48 hours? | ☐ Yes | ☐ No |
| Are you currently taking Accutane or have you taken it in the past?<br>If so, how long ago? _____ months/years | ☐ Yes | ☐ No |

| Medications, Allergies, and Medical History | |
|---|---|
| **Please list all medications you are currently taking:** | **Please list all known allergies:** |
| ☐ | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |

| Please check any conditions that apply to you: | | | |
|---|---|---|---|
| ☐ Autoimmune disease | ☐ Bleeding Disorder | ☐ Cancer | ☐ Diabetes |
| ☐ Heart Disease | ☐ Herpes / Cold Sores | ☐ High Blood Pressure | ☐ Hyperpigmentation |
| ☐ Keloid Scarring | ☐ Migraines | ☐ Neuromuscular Disorder | ☐ Seizures / Epilepsy |
| ☐ Stroke | ☐ Thyroid Disease | ☐ Implants | ☐ Other |
| ☐ History of Facial Surgery (if yes, please list the procedure and year performed: _____) | | | |
| ☐ History of Cosmetic Surgery (if yes, please list the procedure and year performed: _____) | | | |
| ☐ Active Skin Infection (If yes, please describe the condition and treatment, if any: _____) | | | |

By signing below, I certify all information is true and correct to the best of my knowledge.

Signature:_____Today's Date: _____