AESTHETICS 360°
face & body center

PATIENT INFORMATION

GENERAL INFORMATION

Patient Name:_____Today's Date:_____

Mailing Address:_____City:_____

State:_____ Zip code:_____ May we send mail to this address? ☐Yes ☐ No

Date of Birth:_____ Gender:_____ Occupation:_____

Home phone:_____ Is it Ok to call home number? ☐ Yes ☐ No
Is it ok to leave a message at home number? ☐ Yes ☐ No

Cell phone:_____ Is it OK to leave voicemail on cell phone? ☐ Yes ☐ No
Ok to TEXT appointment reminders and special promotions? ☐ Yes ☐ No

Email:_____Ok to email appt. reminders ☐ Yes ☐ No
Would you like to receive occasional emails regarding promotions and events? ☐ Yes ☐ No

Who is your Primary Care Physician?_____

Emergency Contact Name:_____Phone:_____
Emergency Contact Relationship:_____

How did you hear about AESTHETICS 360° Face & Body Center? Please Check all that apply:

☐ Internet Search Engine ☐ Saw our website listed somewhere
☐ Facebook ☐ Instagram
☐ Nails by Mullaney ☐ Hair Salon (name)_____
☐ Neighboring Third Ward Business (name)_____
☐ Friend/Family referral (name)_____
☐ Other, please list_____

AESTHETIC CONCERNS

(Please fill out the accompanying form entitled *Cosmetic Interest Questionnaire*)

What are your primary concerns today, and goals for treatment outcomes?_____

_____

_____

Are you looking to have aesthetic treatments in time for a special event? ☐ Yes ☐ No

If yes, when?_____

SKIN HISTORY

Are you currently using any medication for a skin condition?

☐Accutane ☐Retin-A ☐Hydroquinone or lightening agent ☐Antibiotics (list)_____

Have you ever had a cold sore / fever blister? ☐ Yes ☐ No

Are you prone to thick or raised scars (keloid)? ☐ Yes ☐ No

Do you easily develop areas of hyperpigmentation(skin discoloration)? ☐ Yes ☐ No ☐ Not sure

When were you last exposed to direct sun or a tanning booth?_____

Do you use self-tanners? ☐ Yes ☐ No

Are you planning to vacation in the sun in the next 3 months? ☐ Yes ☐ No

Skin Type: ☐Caucasian ☐African-American ☐Asian ☐Hispanic ☐Native American

☐Other:_____

Would you say you have: ☐ Oily skin ☐ Normal skin ☐ Dry skin ☐ Combination skin

Please list name of products if you currently use, check AM or PM or both:

	AM	PM
Cleanser_____	☐	☐
Exfoliant_____	☐	☐
Toner_____	☐	☐
Moisturizer_____	☐	☐
Antioxidant (Vit.C for example)_____	☐	☐
Retinol / Glycolic_____	☐	☐
Lightener_____	☐	☐
Sunscreen_____	☐	☐
Eye Cream_____	☐	☐
Neck cream_____	☐	☐
Growth Factor_____	☐	☐

LIFESTYLE

Do you smoke? ☐ Yes ☐ No ☐ Occasionally

Do you consume alcohol? ☐ Yes ☐ No If yes, avg. drinks per week_____

Do you engage in exercise or physical activity on a regular basis? ☐ Yes ☐ No ☐ I try

Do you wear contact lenses? ☐ Yes ☐ No

How many hours per day, on average, are you in front of a computer screen?_____

FOR FEMALE PATIENTS

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you taking birth control pills ☐ Yes ☐ No

Are you using any hormone replacement therapy? ☐ Yes ☐ No

AESTHETIC HISTORY

Have you ever had any of the following procedures, check all that apply:

Cosmetic Surgery	☐ Yes	☐ No
BOTOX / Dysport / Xeomin	☐ Yes	☐ No
Dermal Fillers (Juvederm, Restylane, Sculptra, etc.)	☐ Yes	☐ No
Laser Hair Removal	☐ Yes	☐ No
Laser Treatments (Photofacial, IPL)	☐ Yes	☐ No
Kybella	☐ Yes	☐ No
CoolSculpting or other non-surgical fat reduction	☐ Yes	☐ No
Skin Tightening	☐ Yes	☐ No
Chemical Peels	☐ Yes	☐ No
Microdermabrasion / HydraFacial	☐ Yes	☐ No
Dermaplaning	☐ Yes	☐ No
Vein Treatment	☐ Yes	☐ No

Have you ever had an adverse reaction to any of the above procedures? ☐ Yes ☐ No

If yes, explain:_____

MEDICAL HISTORY

Are you currently taking any medications, aspirin, or over the counter supplements? ☐ Yes ☐ No

If yes, Please list:_____

_____

Do you have allergies to any of the following: ☐ Topical skin care products ☐ Latex

☐ Adhesives ☐ Medications ☐ Food ☐ Anesthesia / lidocaine ☐ Plants

If allergic to medications, please list:_____

Have you ever had surgery (excluding cosmetic surgery) ☐ Yes ☐ No

If yes, please list:_____

Are you currently under the care of a physician? ☐No ☐Yes_____

Do you ***now, or have you ever had*** any of the following, check all that apply:

☐ Arthritis	☐ Asthma	☐ Autoimmune disorder	
☐ Any active infection	☐ Bell's Palsy	☐ Bruising / Bleeding disorder	
☐ Cancer_____	☐ Diabetes	☐ Epilepsy or Seizures	☐ Emphysema
☐ Eating disorder	☐ HIV/AIDS	☐ Heart disease / issues_____	
☐ Hepatitis	☐ Herpes Simplex	☐ High Blood Pressure	
☐ Hormone Imbalance	☐ Kidney Issues	☐ Neuromuscular function disorder	
☐ Neurologic disorder	☐ Skin cancer (any type)	☐ Stroke	☐ Thyroid disorder
☐ History of Anxiety, panic attacks, OCD, body image issue			☐ Vision problems
☐ Under the care of a mental health professional			

CANCELLATION AND MISSED APPOINTMENT POLICY

Thank you for choosing AESTHETICS 360° as your provider for medical aesthetic treatments. We strive to provide all of our patients an unmatched 360-degree experience. So that we can accommodate other patients that may want a particular time slot, we require at least 24 hrs. notice for all appointment cancellations. Appointments are confirmed 3 days in advance and again 1 day in advance, via your indicated preferred contact method.

PATIENT SIGNATURE

I_____, have answered all the questions contained on this PATIENT INFORMATION FORM to the best of my knowledge. I understand it is my responsibility to inform my practitioner of my current health conditions when seeking treatment. I will update this information at each visit if there have been any changes to my health.

_____ _____

PRINT PATIENT NAME DATE

_____

PATIENT SIGNATURE