DATE:_____

Rejuvenation Clinic of Sauk Prairie

PATIENT INFORMATION

Patient's name: First: Middle Last	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single / Mar Div / Sep / Widow / Partner
Street address:	Birth date: / /	Age:	Sex: ❑ M ❑ F
City:	State:	ZIP Code:	Home phone : ( )
Email:			Cell phone : ( )
Occupation:	Employer:		Work phone ( )
Emergency contact:	Relationship to patient:		Emergency contact phone: ( )

Referred by (please check):

❑ Health care provider _____

❑Family_____

❑ Friend_____

❑ Internet (site)_____

❑ Other _____

CONCERNS

What Special areas of concern do you have?	**If you could change anything what would it be?**
Which areas would you like to improve? ❑ Acne ❑ Acne Scarring ❑ Enlarged Pores ❑ Age Spots/Brown Spots ❑ Facial redness ❑ Blotchy/uneven skin ❑ Broken capillaries ❑ Stretch marks ❑ Surgical/facial scars ❑ Unwanted hair ❑ Excessive sweating	❑ Thin lips ❑ Fine lines & wrinkles ❑ Sagging facial skin ❑ Sagging body skin ❑ Neck wrinkles ❑ Moles & skin growths ❑ Droopy brows ❑ Droopy eyelids ❑ Spider veins ❑ Nail fungus ❑ Other _____

MEDICAL/SKIN HISTORY

Do you have any of the following-past or present?	**❑ None**		
❑ Acne ❑ Ingrown hairs ❑ Anxiety ❑ Depression ❑ High blood pressure ❑ Low blood pressure ❑ High cholesterol ❑ Pace Maker ❑ Heart Disease/Conditions (list)	❑ Cataracts ❑ Diabetes ❑ Diarrhea/Constipation ❑ Excessive hair growth ❑ Polycystic ovarian syndrome ❑ Ovarian cysts ❑ Cancer (list)	❑ Epilepsy/Seizures ❑ Eating disorder ❑ Headaches ❑ Hepatitis ❑ HIV/Aids ❑ Infections ❑ Lupus ❑ Thyroid (High or Low) ❑ Phlebitis ❑ Serious injury (list)	❑ Hay Fever ❑ Eczema ❑ Menopausal ❑ Melasma ❑ Rosacea ❑ Sleep problems ❑ Severe needle phobia ❑ Claustrophobic ❑ Other (list)

Current medications (over-the-counter and prescription)**:**

Current Health Care Provider/Dermatologist:

Do you smoke? ❑ Yes ❑ No Packs per day: _____ **Other tobacco use:** _____ **Do you wear contact lenses?** ❑ Yes ❑ No	**Are you on oral contraceptives/hormone replacement?** **Are you pregnant or trying to get pregnant?**

	Do you experience hormone imbalances?
How would you describe your overall health? _____ _____ **Is your stress level?** high medium low **Do you regularly exercise?** ❑ Yes ❑ No **If yes, do you cleanse skin after?** ❑ Yes ❑ No **Do you cleanse your face?** ❑ Morning ❑ Evening **Do you wear foundation regularly?** ❑ No **If yes,** ❑ Powder ❑ Liquid ❑ Cream	**What type of skin care products do you use?** **How many glasses of water do you drink daily?** **How many cups of caffeine do you drink daily?**

ALLERGIES

Do you have any allergies? ❑ Drug (list)

❑ Lidocaine ❑ Eggs ❑ Other (list)

Have you ever had a reaction to: ❑ Cosmetics ❑ Metals ❑ Food ❑ Fragrance ❑ Airborne particles ❑ Preservatives
Do you have food intolerances? ❑ No ❑ Yes (what?)

SKIN HISTORY

How would you describe your skin? ❑ Normal ❑ Dry ❑ Oily ❑ Combination ❑ Sensitive ❑ Sun-Damaged	**Do you ever experience:** ❑ Flakiness ❑ Redness ❑ Tightness ❑ Excessive oily shine
Do you blush easily? ❑ Yes ❑ No **If yes, what are the contributing factors?** ❑ Emotions ❑ Foods/drinks ❑ Temperature changes ❑ Other **Do you Bruise easily?** ❑ Yes ❑ No **Are you taking:** ❑ Aspirin ❑ Ibuprofen ❑ Vitamin E ❑ Fish Oil	**Frequent sun exposure?** ❑ Yes ❑ No **Do you use a tanning bed?** ❑ Yes ❑ No **Exposure to chemicals, oils, or other caustic substances that may aggravate your skin?** ❑ No ❑ Yes (what)

Have you ever had these treatments in the past: ❑ Chemical Peels ❑ Microdermabrasion ❑ Dermal Fillers (ex.Juvederm,Perlane) ❑ Botox/Dysport ❑ Laser Phototherapy (IPL/BBL) ❑ Laser Peels ❑ Laser Resurfacing ❑ SkinTyte/Thermage ❑ Plastic Surgery
❑ Permanent makeup ❑
Other:_____
How recently? _____What was your experience?

Are you under treatment for any current skin condition? ❑ No ❑ Yes **What condition?** **How does your skin heal?** ❑ Average ❑ Fast ❑ Slow ❑ Scar easily ❑ With pigment irregularities ❑ Develop Keloids	**Do you get cold sores/blisters?** ❑ No ❑ Yes (where?): **For skin conditions: do you presently or have you ever used?** ❑ Accutane ❑ Retin-A ❑ Hydroquinone ❑ Topical antibiotics ❑ Oral antibiotics ❑ Differin ❑ Renova ❑ Alpha Hydroxy Acids ❑ Tazarac ❑ Any topical prescriptions ❑ **None** For how long? **Do currently take any other skin medications (over the counter or prescriptions)?**

SIGNATURE

Patient signature	***Date***
Guardian (if under 18) signature	***Date***