Today's Date: _____

Rejuvenation Clinic of Sauk Prairie

PATIENT INFORMATION

Patient's name: First Middle Last	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single / Married Divorced / Separated / Widow / Partner
Street address:	Birth date: / /	Age:	❑ M ❑ F ❑ Other
City:	State:	ZIP Code:	Best Contact: ( )
Email:			Can we leave a message on your best contact number? YES NO
Occupation:	Employer:		Alternate number: Cell____ Home____ ( )
Emergency contact:	Relationship to patient:		Emergency contact phone: ( )

Referred by (please check):
❑ Health care provider _____
❑Family/Friend_____
❑Radio_____
❑ Internet (site)_____
❑ Other _____

MEDICAL/SKIN HISTORY

Do you have any of the following- past or present?

❑ High Blood pressure
❑ Low blood pressure
❑ High cholesterol
❑ Blood thinners
❑ Phlebitis/Blood clots
❑ Other blood disorders
_____
❑ Diabetes
❑ Heart disease/Conditions (list)
_____
❑ Pacemaker
❑ Internal defibrillator
❑ Artificial joint/Metal implants
❑Orthopedic metal screws/Plates
❑ Are you able to have an MRI?
❑ Yes ❑ No

❑ Excessive hair growth
❑ Ovarian cysts (PCOS)
❑Copper IUD (Paraguard)
❑ Anxiety
❑ Depression
❑ Sleep problems
❑ Severe needle phobia
❑ Claustrophobic
❑ Eating disorder
❑ Headaches
❑ Epilepsy/Seizures

❑Coldsores/Blisters
❑Past ❑ Present
(where?)_____

❑ Skin cancer
❑ Melanoma
❑ Basal Cell
❑ Squamous Cell
❑ Actinic keratosis
❑ Other cancers (list)
_____
❑ Skin infections
❑ Other infections (list)
_____
❑ Acne
❑ Eczema
❑ Rosacea
❑ Melasma
❑ Vitiligo
❑ Any other skin conditions (list)
_____

❑ Glaucoma
❑ Diarrhea/Constipation
❑ HIV/AIDS
❑ Hepatitis
Any autoimmune diseases(list)
❑ Thyroid (high/low)
❑ Lupus
❑ Scleroderma
❑ Severe allergies
❑ Any other (list)
_____
❑ Serious injuries (list)
_____
❑Any other health conditions (list)
_____

Current medications (please include prescriptions, supplements, vitamins and over-the-counters)**:**

Current Health Care Provider:
Dermatologist:

Currently being treated for any conditions?

Do you smoke? ❑ NO ❑ YES - Packs per day: _____
Alcohol use? ❑ NO ❑ Rarely ❑ 2-3 per week ❑ 2-3 per day ❑ Other_____
Other recreational drugs?

FOR WOMEN:
❑ Oral Contraceptives
❑ Pregnant or Trying
❑Nursing (Breastfeeding)
❑Hormone imbalances
❑ Menopause/Peri-menopause

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 ❑ Other
Do you wear foundation regularly? ❑ Yes ❑ No
If yes, ❑ Powder ❑ Liquid ❑ Cream

What type of skin care products do you use?

What is your daily intake of water (cups)?
❑ 0-2 ❑ 2-4 ❑ 4-6 ❑ 6-8 ❑ more

How many cups of caffeine do you drink daily?
❑ 0-2 ❑ 2-4 ❑ 4-6 ❑ 6-8 ❑ more

ALLERGIES

Do you have any allergies? ❑ Drug (list) _____

❑ Lidocaine ❑ Eggs ❑Nuts ❑ 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
❑ Alcohol ❑ Other
Do you Bruise easily? ❑ Yes ❑ No
Are you taking: ❑ Aspirin ❑ Ibuprofen ❑ Vitamin E ❑ Fish Oil
Do you swell easily? ❑ NO ❑ YES

Frequent sun exposure? ❑ Yes ❑ No ❑ Past ❑ Present
Do you use a tanning bed? ❑ Yes ❑ No ❑ Past ❑ Present

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, Restylane, Sculptra, Artefill) ❑ Botox/Dysport
❑ Skin Phototherapy (IPL/BBL) ❑ Laser Peels ❑ Laser Resurfacing (deep peel and/or fractional) ❑ SkinTyte/Thermage/Ultherapy ❑ Kybella ❑ Emsculpt
❑ CoolSculpting ❑ Plastic Surgery (type):_____ ❑ 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

For skin conditions: do you presently or have you ever used?
❑ Accutane ❑ Retin-A ❑ Hydroquinone ❑ Topical antibiotics
❑ Oral antibiotics ❑ Differin ❑ Renova ❑ Alpha Hydroxy Acids (AHA's)
❑ Metrogel ❑ Finacea ❑ Any topical prescriptions ❑ **None**
For how long?

Do you currently take any other skin medications (over-the-counter or prescriptions)?

SIGNATURE

Patient signature ***Date***

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

Aesthetic Interest Questionnaire

Name: _____

DOB: _____

Today's date: _____

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? **FACE** ❑ Fine lines & Wrinkles ❑ Sagging facial or neck skin ❑ Submental fullness (double chin) ❑ Facial volume loss (cheeks, under eyes) ❑ Droopy brows/Eyelids ❑ Thin lips ❑ Aging mouth/Smokers' lines ❑ Sparse eyelashes or Brows ❑ Acne ❑ Acne Scarring ❑ Enlarged Pores ❑ Age Spots/Brown Spots ❑ Facial blemishes/Skin tags/Milia (bumps) ❑ Facial redness ❑ Broken capillaries or Facial veins ❑ Blotchy/Uneven skin ❑ Unwanted facial hair ❑ Other _____	**BODY** ❑ Excess body fat ❑ Lack of muscle tone/Definition ❑ Sagging body skin ❑ Spider veins on legs ❑ Nail fungus ❑ Moles & Skin growths ❑ Surgical/Facial scars ❑ Unwanted body hair ❑ Excessive underarm sweating ❑ Unwanted tattoo(s) ❑ Other _____ **Would you be interested in a consultation with one of our body contouring specialists?** ☐ YES ☐ NO List key areas of interest:
Would you be interested in a make-up consultation? ☐ YES ☐ NO List key areas of interest:	**Would you be interested in a skincare product consultation?** ☐ YES ☐ NO List key areas of interest:

Skin Typing Matrix

Name:_____

Date:_____

Please answer the following questions by circling the number which best describes you. Your clinician will total your score during the consultation.

My Ethnic origin is closest to:	**Very fair (Celtic and Scandinavian)** **Fair skinned Caucasian with light hair and light eyes** **Pale-skinned Caucasian with dark hair and dark eyes** **Olive-skinned (Mediterranean, some Asian, some Hispanic)** **Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)** **Very dark-skinned (African)**	**--** **--** **--** **--** **--** **--**
My eye color is:	**Light blue** **Blue/Green** **Green/Gray/Golden** **Hazel/Light Brown** **Brown**	**0** **1** **2** **3** **4**
My natural hair color at age 18 was:	**Red** **Blonde** **Light brown** **Dark brown** **Black**	**0** **1** **2** **3** **4**
The color of my skin that is not normally exposed to sun is:	**Pink to reddish** **Very Pale** **Pale with a beige tan** **Light brown** **Medium to dark brown** **Dark brown to black**	**0** **1** **2** **3** **4** **5**
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	**Burn, blister and peel** **Burn, then when burn resolves there is little or no color change** **Burn, but then turns to tan in a few days** **Gets pink, but then turns to tan quickly** **Just tan** **Just gets darker** **My skin color is so dark I can't tell**	**0** **1** **2** **3** **4** **5** **6**
When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	**Longer than one month ago** **Within the past month** **Within the past two weeks** **Within the past week**	**0** **1** **2** **3**

Total _____

If your score is:	**Your skin type is:**
0-3	**1**
4-7	**2**
8-11	**3**
12-15	**4**
16-19	**5**
20-24	**6**

Additional questions:

If you sustain an injury to your skin such as a cut, burn or bruise, how long does it take to fully resolve without any discoloration?_____

What happens if you get an insect/mosquito bite?

_____