Aesthetic Skin Care of NJ

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Date_____

Name: Last_____ First _____

Address: Street_____

City_____ State_____ Zip_____

Sex: _Male _Female Marital Status _____ Birth Date_____

Driver's License Number: _____ **(We require ID for ALL CONSULTATONS)**

Phone: Home_____ Work_____ Cell_____

Email_____

How did you hear about us? _____

Primary Care Physician_____ Phone_____

Physician Address_____

Emergency Contact_____ Phone _____

Today's visit is regarding: (check all that apply)

Injectable /Skin Treatments

__ Botox

__ Injections (Fillers)

__HydraFacial

__ IPL (Laser)

Micropigmentation/Tattooing

___ Brows

___ Scalp

___Eyeliner

___Skin Camouflage

___ 3D Nipple/Areola Tattooing

___ Lips/Lip Liner

___Eyelash Enhancement

___Scar Revision

Areas of Concerns:

___Lines between Eyebrows

__ Lip Fill

___Cheeks

___ Chin/Jawline

___ Under Eye (Dark Circles)

Where did you have your last treatment?

___ Medical Spa

___Doctor's Office

___Other

___Hair Salon

___Spa

Did you have any skin sensitivity or reaction to the treatment? If so, what? _____

_____

Do you get fever blisters? _____

Have you ever had: (check all that apply)

___ Permanent Cosmetics/Tattooing
___ Microdermabrasion
___ Chemical/Acid Peel
___ HydraFacial
___ Dermalplaning
___ Skin Bleaching
___ Laser/IPL
___ Laser Hair Removal
___ Botox/Dysport
___Facial Fillers

Are you interested in: (check all that apply)

___ Permanent Cosmetics/Tattooing
___ Microdermabrasion
___ Chemical/Acid Peel
___ Hydrafacial
___ Dermalplaning
___ Skin Bleaching
___ Laser/IPL
___ Laser Hair Removal
___ Botox/Dysport
___Facial Fillers

Have you had any operations, including minor surgery or cosmetic surgery? _____

_____

Have you had any reactions to anesthesia? If so, what? _____

_____

Do you have any allergies to food or medications? If so, what? _____

_____

Please list any medications you are currently on:

_____

_____

_____

_____

Have you ever had or do you currently have: (check all that apply)

___ Asthma
___ High Blood Pressure
___ Hepatitis
___ Blood clot
___ Heart Disease
___ Eye Problems
___ Cold Sores/Fever Blisters
___ Cancer

Do you bleed or bruise easily? _____

Have you used accutane? _____

For women:

Are you pregnant or nursing? ___ yes ___no

Are you trying to get pregnant? ___ yes ___ no

Are you on hormone therapy? ___ yes ___ no

Is there any additional information that you may want to add that we may not have asked you previously?
_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge; the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____Signature

Date