PHYSICIAN'S AGELESS SOLUTIONS
NONSURGICAL SOLUTIONS

Welcome

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Referred By: _____

Address: _____

Home Phone: _____ Cell: _____ May we communicate by text? _____

Email address: _____ May we email you? _____

Emergency Contact: _____ Relation: _____

Occupation: _____ Does your job require that you work outdoors? ·No ·Yes

List all medications and supplements:

Please check any condition that you currently have or have had in the past:

·Heart Problem ·Diabetic ·HIV ·Lupus ·Hepatitis ·Auto Immune Disease ·Bruise Easily
·Poor Wound Healing ·Asthma ·Eczema ·Psoriasis ·Vitiligo ·Keloid Scar ·High Blood Pressure
·Pacemaker or Implanted Defibrillator ·Metal Implant ·Seizure ·Epilepsy · Anxiety ·Depression
·Hyper Thyroid ·PCOS ·Permanent Makeup ·MS ·ALS · Bell's Palsy ·Cold Sores ·Shingles

Skin History

1) Which of the following best describes your skin when exposed to the sun for 30 minutes & no SPF:

· Always burns easily, never tans with very pale skin tone (Fitz I)
· Always burns, tans with a hint of color with very pale skin tone (Fitz II)
· Burns initially, tans gradually with light skin tone (Fitz III)
· Can burn and can tan with olive/gold skin tone (Fitz IV)
· Rarely burns with brown skin tone (Fitz V)
· Rarely burns with very deeply pigmented skin tone (Fitz VI)

2) When were the last injections to your face? Date: _____

To what Area(s) of the Face? _____

What Specific Products were used? _____

Any adverse reaction(s) experienced with those injections? _____

_____

3) Any surgeries to the face, and/or history of trauma to the face? Date, and Please describe:

4) Have you ever had chemical peels, laser or microdermabrasion? ·No ·Yes

In the last month? ·No ·Yes If yes, please describe: _____

5) Do you use Retin-A, Renova, Hydroquinone, Hydroxyl Acid or Retinol/vitamin A derivative products?

·No ·Yes If yes, please describe: _____

6) Have you used an acne medication? ·No ·Yes When? _____ What type? _____

7) What skin care products are you currently using? (List brand)_____

8) Have you recently used any self-tanning lotions, creams or treatments ·No ·Yes

Please specify: _____

9) What SPF do you use on your face? _____ How often? _____

10) In the last 2 weeks, have you had injections of ANY TYPE to the face? ·No ·Yes

Please specify: _____

Allergies

Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)

·Cosmetics ·Medicine ·Food ·Animals ·Sunscreens ·Iodine ·Pollen ·AHA

·Fragrance ·Salicylic Acid ·Shellfish ·Latex ·Drugs ·Sun ·Numbing agents

KNOWN DRUG ALLERGIES: _____

If yes, please explain: _____

Female Clients Only:

1) Are you taking oral contraceptives? ·No ·Yes

Please specify: _____

2) Any recent changes to or from your contraceptive treatment? ·No ·Yes If so, what and when: _____

3) Are you pregnant or trying to become pregnant? ·No ·Yes

4) Are you lactating? ·No ·Yes

5) Any menopause problems? ·No ·Yes

Please specify: _____

6) Are you undergoing any hormone replacement therapy? ·No ·Yes

Please specify: _____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from your treatment that may be irreversible. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

Client Signature:

_____

Date: _____

Physician Signature:

_____

Date: _____