NORTHWEST ARKANSAS

Skin Care Center

Patient Profile for Aesthetic Services

(Please print legibly and fill in or correct all fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt. # City State Zip

Home Phone _____ Cell Phone _____ Email _____

Preferred Contact Method:
☐ Email Text ☐
☐ Home Cell ☐

May we send text reminders? YES NO

May we add you to our email list? YES NO

Any contact restrictions? _____

Pharmacy Preference _____

Age _____ Birthdate _____ SS# _____ Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married to: _____ Other: _____

Patient's Employer _____ Occupation: _____

Address _____
Street & Apt. # City State Zip

Work Phone _____ Ext. _____ Who is your primary care physician? _____

How did you hear about us? ☐ Google ☐ CitiScapes Magazine ☐ Peekaboo Magazine ☐ Doctor _____

☐ Friend/Relative _____ ☐ Other _____

If you were referred by a specific person, may we thank them? YES NO

Emergency Contact: _____ Relationship to patient: _____

Home phone: _____ Work phone: _____ Other phone: _____

Areas of interest: (mark all that apply)

<u>Facial Procedures</u>
- ☐ Blepharoplasty
- ☐ Botox
- ☐ Brow or Forehead Lift
- ☐ Earlobe Repair
- ☐ Facial Liposuction (Neck, Jowls)
- ☐ Face or Neck Lift
- ☐ Lip Enhancement
- ☐ Otoplasty (Ear Pinning)
- ☐ Rhinoplasty (Nose Job)
- ☐ Skin Resurfacing (Laser, Peel, Etc.)
- ☐ Wrinkle Fillers (Injectables)

<u>Breast Procedures</u>
- ☐ Breast Augmentation
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Mastopexy (Breast Lift)
- ☐ Nipple Reduction or Inversion

<u>Body Procedures</u>
- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Brachioplasty (Arm Lift)
- ☐ Liposuction (Thighs, Abdomen, Etc.)
- ☐ Thigh or Buttock Lift
- ☐ Fat Grafting

<u>Other Procedures</u>
- ☐ Skin Care
- ☐ Telangectasia (spider veins)
- ☐ Laser Hair Removal
- ☐ Leg Veins
- ☐ Lesions / Moles
- ☐ Wound Repair

I understand that office visit charges are payable on the day service is rendered.

Signature _____ Date _____

Please list all current medications you are taking, including oral and topical prescriptions, over-the-counter herbs, vitamins, and supplements: _____

_____

Drug Allergies: _____

Are you pregnant or nursing? ☐ Yes ☐ No

Do you currently use or receive dipilatories or waxing? ☐ Yes ☐ No

Are you applying any topical medications at this time? ☐ Yes ☐ No

If yes, which ones? _____

Are you currently using any topical Retinoid or any other prescribed topical Vitamin A derivative? (trentinoin/Retin-A/ Renova/Differin/Tazorac/Avage/EpiDuo/Ziana) ☐ Yes ☐ No

If yes, what strength? _____ How long? _____

Are you currently using Accutane? ☐ Yes ☐ No How long? _____

Have you used Accutane in the past? ☐ Yes ☐ No

Have you had a chemical peel or any type of procedure with a medical device? ☐ Yes ☐ No

Within the last 14 days? ☐ Yes ☐ No

Have you had collagen, Botox or other dermal filler injections? ☐ Yes ☐ No

Any recent facial surgery? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No

Do you develop cold sores / fever blisters? ☐ Yes ☐ No Last breakout? _____

Please list your current skin care regimen: _____

_____

What are your primary skin concerns? _____

_____

Have you used skin care products that caused a bad reaction? ☐ Yes ☐ No

If yes, please describe: _____

_____

Describe any serious health conditions, if any: _____

_____ _____

Patient's Printed Name Date

_____

Patient's Signature (or guardian, if a minor)

_____ _____

Witness Signature Date