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New Britain, CT 06052
#860-229-8346

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Madison, CT 06443
#203-245-8346

This form is to introduce you to our facility and to help us better serve you. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Please complete the following:

Name: _____ Date of Birth: ___ / ___ / ___

Address: _____

City / State / Zip _____

Home Phone # _____ Cell Phone # _____

Email Address: _____

How did you hear about us? : _____

Which phone # may we use to contact you? _____

Can we leave a message at this number?: _____

May we speak with your spouse / significant other / family regarding your treatment? _____

May we contact you via Email? Yes No Email address: _____

Would you like to receive our monthly promotional offers via email (you may opt out at any time)?
 Yes No

Please advise any additional requests for privacy below:

Print Client Name: _____

Signature of Client: _____
(Client/Parent or Guardian if patient is under 18) Date

Please print name if you are the Parent/Guardian: _____



Personal Profile and Medical History:

Females: Are you pregnant?
 Yes No

Are you breastfeeding?
 Yes No

Medical History:

Please complete the following items and always inform of us any changes in your medical history and / or medications.

Medications (prescription and over the counter drugs, vitamins, herbs, and / or supplements):

***ALLERGIES** to any medications? _____

Symptoms: (please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Precocious Puberty |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hirsutism | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Burns/skin grafts | <input type="checkbox"/> Hormone Replacement Rx | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kaposi's Sarcoma |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Eczema | <input type="checkbox"/> Keloid Scars |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Tattoos | <input type="checkbox"/> Epidermolysis Bullosa | <input type="checkbox"/> Polycystic Ovary Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Port Wine Stain |
| <input type="checkbox"/> Vitiligo | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Permanent Makeup | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hepatitis | | |

Surgeries: _____

Please list any other pertinent medical information: _____

PERSONAL PROFILE & MEDICAL HISTORY – Continued:

- | | | |
|--|-----|----|
| 1. Have you used Accutane in the last 6 months? | Yes | No |
| a. If yes, how recently? _____ | | |
| 2. Are you currently using glycolic acid or Retin A? | Yes | No |
| 3. What products are you currently usng on your skin? | | |
| a. Describe: _____ | | |
| 4. Do you have any active skin diseases or infections in the area to be treated? | Yes | No |
| 5. Are you allergic to latex, lidocaine, or any lotions? | Yes | No |
| 6. Have you had any permanent cosmetic tattooing to the area to be treated? | Yes | No |
| 7. Do you have any metal or other implants? Where? _____ | Yes | No |
| 8. Have you had any previous laser treatment or other skin treatments to the area to be treated? Describe: _____ | Yes | No |
| 9. Are there any moles with hair in the area to be treated? | Yes | No |
| 10. Do you have history of skin breakouts? | Yes | No |
| 11. Do you have any scarring as a result from your breakouts/acne? | Yes | No |
| 12. Have you been exposed to sun with the last 4 to 6 weeks? | Yes | No |
| a. If yes, approximate date of last exposure _____ / _____ / _____ | | |
| 13. Do you use tanning beds? If yes, date of last use _____ / _____ / _____ | Yes | No |
| 14. Do you burn easily in moderate sunlight? | Yes | No |
| 15. Do you blush when nervous? | Yes | No |
| 16. Do you frequently experience flakiness, tightness or dryness? | Yes | No |
| 17. Do you use sunscreen on a regular basis? | Yes | No |
| 18. Have you waxed, used depilatories, bleaches or other chemicals? | Yes | No |
| 19. How much water do you normally consume daily? _____ | | |
| 20. Do you smoke? | Yes | No |
| 21. Do you wear contact lenses? | Yes | No |
| 22. Do you exercise? | Yes | No |
| 23. Have you had microdermabrasion? | Yes | No |
| 24. Have you had any chemical peels? | Yes | No |
| 25. Have you had laser resurfacing? | Yes | No |
| 26. Do you have wrinkle concerns? | Yes | No |
| 27. Do you have scarring concerns? | Yes | No |
| 28. Do you have sun damage concerns? | Yes | No |
| 29. Do you have pigmentation concerns? | Yes | No |
| 30. Do you have broken capillary concerns? | Yes | No |



What services are you most interested in? _____

Name of family doctor: _____ Phone # _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Print Patient Name: _____

Signature: _____ **Date:** _____
(Parent or Guardian if patient is under 18)

Physician's Signature: _____

***I understand that payment for any cosmetic services or products is expected in full at the time of service.**

Signature: _____ **Date:** _____
(Parent or Guardian if patient is under 18)
