Philadelphia
FACIAL PLASTIC SURGERY
& MEDSPA

Aesthetics Intake Form

GENERAL INFORMATION

Name:	Today's Date:	Occupation:	
Address:	City:	Province:	Postal Code:
Phone #:	Date of Birth:	Email:	
Emergency Contact:	Phone #:	How did you hear about us?	
Preferred Method of Communication: ☐ Email ☐ Phone	Name of Person Who Referred You:		

GENERAL HEALTH

Rate your level of Stress *(1 = lowest; 5 = highest)*: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What physical activities do you enjoy?

Do you wear contact lenses? ☐ YES ☐ NO | Are you claustrophobic? ☐ YES ☐ NO

Please list any accidents or surgeries in the past 12 months:
(if you have had surgery in the past 12 months)

Do you have? Metal Implants ☐ YES ☐ NO | Pace Maker ☐ YES ☐ NO | Body Piercings ☐ YES ☐ NO

List any medication(s)/supplement(s) you are taking:

Are you currently taking? ☐ Antibiotics ☐ Birth Control ☐ Hormone Replacement ☐ Blood Thinners

HEALTH HISTORY – *Please check here if none apply* ☐

☐ Arthritis	☐ Facial Warts	☐ Herpes Simplex Virus	☐ MRSA	☐ Citrus Allergy
☐ Rosacea	☐ Sun Burn/Allergy	☐ Eye Infection/Disorder	☐ Smoker	☐ Sulfates/Sulfur Allergy
☐ Lupus/Autoimmune	☐ Headaches	☐ Heart Disease	☐ Diabetes	☐ Sciatica
☐ Soy Allergy	☐ Wheat Allergy	☐ Nut Allergy	☐ Seaweed Allergy	☐ Eczema
☐ Psoriasis	☐ Other			

Have you ever been diagnosed with Cancer? ☐ YES ☐ NO | Are you pregnant or trying to become pregnant? ☐ Yes ☐ NO

Any other medical conditions or concerns we need to know about? Explain:

SKIN CARE

Are you currently under the care of a Dermatologist? ☐ YES ☐ NO

Do you use any of the following topical products?

☐ Accutane	☐ Retin A/Stiva A	☐ Isotretinion	☐ Adapalene	☐ Differin
☐ Vitamin C	☐ Tretinoin/Avita	☐ Scrub/Peel		

☐ Other prescription topical skin products. Please be specific:

Have you had any of the following? ☐ Chemical Peel ☐ Botox ☐ Microderm ☐ Dermal Filler ☐ Permanent Cosmetics

☐ Other resurfacing treatments. Please be specific:

Any serious side effects? ☐ YES ☐ NO If YES, please specify:

Are you currently using any products that contain the following? ☐ Glycolic Acid ☐ Lactic Acid ☐ Hydroxy Acid ☐ Vitamin A ☐ Vitamin C

Have you had an allergic reaction to any waxing or skincare products? ☐ YES ☐ NO Explain:

SKIN MAINTENANCE

Skin Condition/Type: ☐ Oily/Congested ☐ Dry/Dehydrated ☐ Sensitive/Redness ☐ Acne/Breakouts ☐ Sunburned

Have you been tanning in the last 24 hours? ☐ YES ☐ NO

In the last week have you had? ☐ Waxing ☐ Laser ☐ Electrolysis

Do you use sunscreen? ☐ YES ☐ NO If so, what SPF?

What are your primary skin care goals? ☐ Anti-Aging ☐ Sensitivity ☐ Acne/Breakouts ☐ Brightening/ Lightening

Comments:

PRODUCTS USED – List Brand and Frequency of Use

	Brand	Frequency
☐ Soap/Cleanser		
☐ SPF		
☐ Toner		
☐ Exfoliator		
☐ Masque		
☐ Moisturizer		
☐ Serum		

Signature:_____ Date:_____