SKIN WELLNESS
PHYSICIANS

Aesthetic Registration:

First Name: ___________________________ M.I. ______ Last Name: _____________________________________

Date of Birth: _______/_______/_______ Gender: Female / Male
(month) (day) (year)

Address: ____

City: ____ State: _________ Zip Code: _____________________

Home Phone: _____________________________________ Cell Phone: _____________________________________

Email Address: ____

How did you hear about us? ____

Would you like to receive the following? Appointment Reminders: Yes / No Promotions: Yes / No

If yes, how would you like to be contacted? Phone / Email / Text (circle all that apply)

Allergies: ____

Medications:

Pharmacy: _____________________________________ Phone number: ____________________________________

I have the following concerns/symptoms: (select all that apply)

- ☐ Acne Scars
- ☐ Age/Sun Spots
- ☐ Brown/Red Spots
- ☐ Enlarged Pores
- ☐ Facial Rejuvenation
- ☐ Facial Veins
- ☐ Melasma
- ☐ Scarring
- ☐ Uneven Skin Tone
- ☐ Wrinkles
- ☐ Loss of vaginal lubrication/tone

Have you ever had treatment for any of the above or any type of cosmetic/aesthetic treatment (i.e. botox, fillers, laser, facial)? If so, please list:

Treatment Type	Treatment Area	When?	Where?

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Which of the following best describes your skin type? (please check **one**)

☐	I	Always Burn	☐	IV	Rarely Burn, Always Tan
☐	II	Always Burn, Sometimes Tan	☐	V	Brown, Moderately Pigmented Skin
☐	III	Sometimes Burn, Always Tan	☐	VI	Black Skin

Skin Type

☐ Normal ☐ Oily ☐ Dry ☐ Combination

SKIN DISEASE HISTORY: (Please CIRCLE all that apply)

Acne	Actinic Keratosis	Asthma	Basal Cell Skin Cancer
Blistering Sunburns	Dry Skin	Eczema	Flaking or Itchy Scalp
Hay Fever/Allergies	Melanoma	Poison Ivy	Precancerous Moles
Psoriasis	Squamous Cell Skin Cancer		NONE OF THE ABOVE

Other:
____

Do you wear Sunscreen? Yes No
If yes, what SPF? ________________

Do you tan in a tanning salon? Yes No

Do you have annual or biannual skin exams?Yes No

If not, would you like to schedule a skin exam? Yes No

Patient signature: ____ Date: ___________________

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