SKIN WELLNESS
PHYSICIANS

Cosmetic 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
- ☐ II Always Burn, Sometimes Tan
- ☐ III Sometimes Burn, Always Tan
- ☐ IV Rarely Burn, Always Tan
- ☐ V Brown, Moderately Pigmented Skin
- ☐ 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: _____