RejuvenationMD®
Aesthetic Skin Treatment & Wellness Center

NEW PATIENT INFORMATION & MEDICAL HISTORY (PAGE 1 OF 2)

PATIENT DEMOGRAPHICS (CAPITAL LETTERS PREFERRED)

Name: ____ Birthday: _____ /_____ /_____

Mailing Address: ________________________ City: __________________ State: _______ Zip: _______

Home Phone: (   ) _________ - _________   Cell Phone: (   ) _________ - __________

Preferred Telephone Contact: ☐ Cell Phone ☐ Home Phone

Email Address: ____

Occupation: ______________________________ Employer: ___________________________________

Emergency Contact: _________________ Phone: (   ) _____ - _____ Relationship: _______________

How were you referred to us? ____

COSMETIC CONCERNS

What concerns do you have that brought you in today?

☐ **Acne** ☐ **Hair Loss** ☐ **Rosacea** ☐ **Urinary Incontinence**

☐ **Cellulite** ☐ **Hyperpigmentation** ☐ **Sagging Skin** ☐ **Unwanted Hair**

☐ **Double Chin** ☐ **Melasma** ☐ **Scars** ☐ **Vaginal Aging/Dryness**

☐ **Excess Fat** ☐ **Nail Fungus** ☐ **Sexual Wellness** ☐ **Excess Sweat**

☐ **Veins** ☐ **Pores** ☐ **Under Eye Bags** ☐ **Wrinkles**

How long has (have) this (these) bothered you?____

What have you tried in the past?____

Have you had a consultation regarding these concerns? ☐ Yes ☐ No

If so, what prevented you from moving forward?____

Is there a specific timeframe you are working with and why? ______________________________________

Do you have a budget that you would like to stay within? ____

Are there specific procedures you are interested in? (Check all that apply)

☐ **Coolsculpting** ☐ **BBL Forever Young** ☐ **Moxi** ☐ **Hair Restoration**

☐ **Cool Tone** ☐ **Diva** ☐ **Hair Removal** ☐ **Halo Skin Resurfacing**

☐ **Chemical Peels** ☐ **Scarlet** ☐ **Kybella** ☐ **Breast Lift**

☐ **Facials** ☐ **Fillers** ☐ **Sculptra** ☐ **Non-Surgical Facelift**

☐ **Botox** ☐ **Sofwave** ☐ **Agnes** ☐ **PDO Threads**

☐ **Vein treatments** ☐ **Microneedling** ☐ **Sexual Wellness Treatments for Men/Women**

☐ **Other:** ____

COSMETIC HISTORY

Have you ever had or received any of the following noninvasive aesthetic procedures? (Check all that apply)

☐ **Botox** ☐ **Fillers** ☐ **IPL/Photofacials** ☐ **Facials**

☐ **Hair Removal** ☐ **Body Contouring** ☐ **Laser Resurfacing** ☐ **Skin Tightening**

☐ **Other:** ____

NEW PATIENT INFORMATION & MEDICAL HISTORY PAGE (2 OF 2)

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Do tan regularly (naturally or artificially including salons, spray tans or tanning creams)? ☐ Yes ☐ No

Do you have any permanent makeup/tattoos on your face? ☐ Yes ☐ No. If yes, where?_____________

Have you had any of the following aesthetic procedures? (Check all that apply)

☐ Facelift **☐ Neck Lift** **☐ Breast Surgery** **☐ Eyelid Surgery**

☐ Other:____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, who?______________________

Are you currently under the care of a dermatologist? ☐ Yes ☐ No If yes, who? ____________________

Do you have any known ALLERGIES: ☐ Yes ☐ No If yes, please list:__________________________

Name and city for your pharmacy:____

Do you smoke? ☐ Yes ☐ No If yes, check all that apply: ☐ Tobacco ☐ MArijuana ☐ Vape

Do you drink alcohol? ☐ Yes ☐ No

Do you have any of the following medical conditions? (Check all that apply)

☐ Cancer **☐ Diabetes** **☐ Metal Implants (incl IUDs)** **☐ High blood pressure**

☐ Cold Sores **☐ Genital Herpes** **☐ Migraines** **☐ Seizure Disorder**

☐ Hepatitis **☐ Hormone Imbalance** **☐ Sexual Dysfunction** **☐ Urine Incontinence**

☐ Seizure Disorder **☐ Clotting Issues** **☐ Autoimmune Disease** **☐ HIV/AIDS**

Please list any other health conditions: ____

For females: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

MEDICATIONS

Please list any **oral** medications that you are taking: ____

Please are you taking any of the following medications? (Check all that apply)

☐ Birth Control ☐ Hormones ☐ Aspirin/NSAIDS (Ibuprofen, Naprosyn)

☐ Blood Thinners (such as Coumadin, Warfarin, Plavix, Xarelto, Aggrenox, Pletal)

Have you ever used Accutane? ☐ Yes ☐ No If yes, when did you last use it?___________________

Are you using any of the following **topical** medications or creams? (Check all that apply)

☐ Retin-A© ☐ Hydroquinone or bleaching agents Others (Please list):____________________

ACKNOWLEDGEMENT

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor, esthetician, or staff of my current medical conditions/medications and to update this history. I understand that any products or procedures not utilized within 12 months of purchase date will be forfeited. I also have been made aware that there are no refunds for deposits, payments or treatments received, 2 days' notice is required for cancellations, or a fee may be incurred, and children & pets are not recommended and/or allowed to be in the office.

Signature: ____ **Date:** ____________________

SKIN MATRIX

Name: ____Date: _________________

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Please answer the following questions by circling the number which best describes you.

My ethnic origin is closest to:	Very fair	0
	Fair-skinned with light hair and light eyes	1
	Pale-skinned with dark hair and dark eyes	2
	Olive-skinned	3
	Dark-skinned	4
	Very dark-skinned	5
My eye color is:	Light blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light brown	3
	Medium to dark brown	4
	Dark brown - black	5
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is very dark, therefore there is no color change	6

Total:

If your score is:	Your skin type is:
0 – 3	1
4 – 7	2
8 – 11	3
12 – 15	4
16 – 19	5
20 – 24	6
24+	