DEANA COLATRIANO DOWNEY
AESTHETICIAN

Date: ____________________ ID # ____________________

Personal Information

First Name ____________________ Last Name ____________________

Address ____________________ City, State, Zip ____________________

Home Phone ____________________ Cell Phone ____________________

Date of Birth ____________________ Email Address ____________________

Emergency Contact Name & Phone ____

Reason for Visit ____

How did you hear about us? ____

Treatment & Product History

Have you ever used Accutane? Y or N When last? ____________________

Have you ever used? ___Retin-A ___Glycolic Acid When last? ____________________

Have you ever had? ___Chemical Peel ___Laser Resurfacing ___Facial Surgery
When last? ____________________

Have you had any fillers or injectables? Y or N When last? ____________________

Medical History

Current Medications

____

What oral medications do you use or have you used in the recent past?

____

Antibiotics ____________________ Diuretics ____________________

Hormones/Birth Control ____________________ When last? ____________________

Do you take herbal supplements? Y or N

Are you under the care of a Physician or Dermatologist? Y or N
Please explain ____

Do you have any of the following medical conditions? Y or N

___ Cardiac Problems (pacemaker or defibrillator)
___ Bleeding disorders or Bruise easily
___ Do you take anticoagulants or aspirin?
___ Diseases stimulated by light (Epilepsy,Lupus)
___ Diseases stimulated by heat (Herpes Simplex)
___ Skin disorders or Skin lesions
___ Hormone imbalance (PCO)
___ Melasma
___ HIV/AIDS
___ High Blood Pressure
___ Keloid /Scarring
___ Impaired healing
___ Cancer
___ Arthritis
___ Frequent Cold Sores
___ Diabetes
___ Hepatitis
___ Thyroid

Please explain if you have checked any of the medical conditions:

____

Do you smoke? Y or N If Yes, how much?

Do you consume alcohol? Y or N If yes, how much?

Do you exercise? Y or N If yes, how much?

Surgical History Please list all surgeries

____

IPL/Laser History Please list treatments

____

Liposuction History Please list treatments

____

Skin Type

Ethnicity: ___White ___Asian ___Hispanic ___Mediterranean ___Middle Eastern ___Black ___Combination

Do you burn? Y or N
Sometimes burn? Y or N
Never Burn? Y or N
Usually burn? Y or N
Rarely burn? Y or N
Broken Capillaries? Y or N
Nose Area? Y or N
Cheek area? Y or N
Chin area? Y or N
Forehead? Y or N

Do you spend a lot of time in the sun? Y or N

Do you use sun block? Y or N What SPF? ____________________

How often do you apply sunscreen? ____________________

Do you have frequent breakouts? Y or N

Is your skin: ___Oily ___Dry ___Tight ___Flaky

What skin products do you use?
____

Tattoos

Do you have any tattoos? Y or N Location: ____________________

Is your tattoo professional? Y or N How old is your tattoo? ____________________

Have you had tattoo removal treatments elsewhere? Y or N
Where? ____________________

Do you have any problems with hypopigmentation or hyperpigmentation? Y or N

Female Patients Are you pregnant? Y or N Are you breastfeeding? Y or N

Signature ____ Date ____________________

Witness ____