SKINRITUAL

Patient Intake Form

Name: _____ **DOB:** _____/_____/_____ **Gender:** Male ____ Female ____

Phone Number: _____ **Email:** _____

Okay to leave detailed messages on voicemail? (Please circle) Yes No

- ☐ I give my consent to receive messages on my cell phone via text for appointment reminders. These messages may contain office promotions.
- ☐ I decline cell phone text messages

Would you like to receive emails about office specials/promotions? (Please circle) Yes No

- ☐ I give my consent for Skin Ritual to communicate with me via email regarding my care
- ☐ I decline email communication

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Occupation: _____

Emergency Contact: _____ **Phone Number:** _____

Okay to discuss my health or billing information with:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

- ☐ Do not discuss my information with anyone

<u>How did you hear about us?</u> (Please check all that apply)

___Instagram Account: (circle one) @the_skinritual @the_aesthetician @the_dermgirl

@thebossyderm @_thedermpa @jennayount_aesthetics @leximacqueen_aesthetics

___Desert Sky Dermatology ___Friend/Family:_____

___Yelp ___Google ___Facebook ___Dermatologist Other: _____

Reason for visit: _____

Health History

Previous Procedures: Which of the following have you had in the past? (Please check all that apply)

___ Neurotoxins (i.e. Botox, Dysport)

___ Injectable Fillers (i.e. Juvederm, Restylane)

___ Sculptra

___ PDO Threads

___ Facials

___ Dermaplane

___ Hydrafacial or DiamondGlow

___ Chemical Peels

___ Microneedling

___ RF Microneedling (i.e. Vivace, Morpheus8, Scarlet, Sylfirm)

___ Moxi or Clear + Brilliant lasers

___ Laser Resurfacing (i.e. Halo, Fraxel, CO2)

___ BBL, IPL, or Photofacial

___ Permanent Makeup or Microblading

___ Facial Cosmetic Surgery:_____

Current Medications: (Including topical medications like Retin-A, tretinoin, etc.)

_____

_____

Allergies: (Including latex, medications, food, etc.)

_____

_____

Are you pregnant? **Y N** Are you nursing? **Y N** Are you planning on becoming pregnant? **Y N**

Are you currently taking ACCUTANE, or have you taken Accutane in the last 6 months? **Y N**

Do you use tanning beds? **Y N** Do you wear sunscreen DAILY? **Y N** Do you smoke? **Y N**

Any Dental work/cleaning in the last 2 weeks, or an upcoming appointment in the next 2 weeks? **Y N**

Past Personal Medical History: (Please check all that apply)

___Autoimmune Disease

___Hyperthyroid

___Hypothyroid

___Blood Clots, Bleeding Disorders

___Cancer

___Cold Sores (ever, even years ago)

___ Connective Tissue Disorder

___HIV/AIDS

___IUD (current)

___Diabetes

___Fibromyalgia

___Heart Disease

___Hepatitis B or C

___Hormone Therapy

___High Blood Pressure

___Lyme Disease

___Lupus

___Metal Implants or Plates

___PCOS

___Seizures

___Stroke

___Hysterectomy

___Cochlear implant, Pacemaker, Defibrillator, or any other electrical devices

Other: _____

Previous Surgeries: _____

_____