Paradise Valley Aesthetics

Aesthetics Health Evaluation Form

Name___________________________ Date of Birth_________ Age___

Family Physician Name:___________________________________

HISTORY/MEDICAL INFORMATION

Please tell us your present concerns:____

____

Have you ever been treated for or are you currently being treated for: (circle)

Acne Psoriasis Dermatitis Fever Blisters Diabetes Cancer Depression Seizures
Active Herpes Infection Keloid Scars Open Lesions Immunosuppression

Explanation for any items circled above:____

Are you currently using or have you ever used any of the following? (circle)

Accutane Acyclovir/Valtrex Tetracycline Tazorac Retin-A
Alpha/Beta Hydroxy Acids Oral or Topical Antibiotics

Are you currently on Hormone Therapy or Hormonal Birth Control? □Yes □No

Are you pregnant? □Yes □No Are you trying to get pregnant? □ Yes □No

Are you breast feeding? □ Yes □No

Date of your last menstrual period__________ Are periods regular? □Yes □No

Please list any allergies you have to medications or cosmetic products:
____

Do you smoke? □Yes □No If yes, how many packs a day?_____

How long have you been smoking for?______ Do you live with a smoker?□Yes □No

Do you drink alcohol? □Yes □No If so, how often?______________________

Do you wear contact lenses? □Yes □No

Cont'd

Please check any of the following if you had in the past or currently have:

Asthma	___Yes	___No	Cancer	___Yes	___No	Chest Pain	___Yes	___No
Artificial Heart Valve	___Yes	___No	Blood Transfusion	___Yes	___No	Emphysema	___Yes	___No
Cosmetic Surgery	___Yes	___No	Cortisone Medication	___Yes	___No	Heart Surgery	___Yes	___No
Diabetes	___Yes	___No	Dizzy/Fainting	___Yes	___No	Heart Pacemaker	___Yes	___No
Drug Addiction	___Yes	___No	Epilepsy or Seizures	___Yes	___No	High Blood Pressure	___Yes	___No
Glaucoma	___Yes	___No	Heart Failure	___Yes	___No	Kidney Disease	___Yes	___No
Hay Fever	___Yes	___No	Genital Herpes	___Yes	___No	Nervous Disorder	___Yes	___No
Hemophilia	___Yes	___No	Heart Murmur	___Yes	___No	Rheumatism	___Yes	___No
Hepatitis B	___Yes	___No	Heart Attack	___Yes	___No	Stroke	___Yes	___No
Hepatitis C	___Yes	___No	HIV Positive	___Yes	___No	Sinus Trouble	___Yes	___No
Leukemia	___Yes	___Yes	Liver Disease	___Yes	___Yes	Shortness of Breath	___Yes	___No
Psychiatric Treatment	___Yes	___Yes	Rheumatic Fever	___Yes	___Yes	Thyroid Disease	___Yes	___No
Tuberculosis	___Yes	___No	Venereal Disease	___Yes	___No			

Please list all medications and/or vitamins, supplements and herbs you are currently taking:_____________________

____

Please list all of your surgeries:____

____

Have you taken the prescription drugs Fenfluramine, Fenfluramine combined with Phentermine (Fen-phen), Dexfenfluramine (Redux), or other weight loss products? □Yes □No

Advanced Directive Information:_______________________Living Will? □Yes □No

***Patient's Signature:*_________________________ *Date:*______________**

***Reviewed by Doctor:*________________________**

***Doctor's Notes:*____**

Paradise Valley Aesthetics

SKIN HEALTH INFORMATION

PATIENT NAME______________________________ Date of Birth___________ Age___

What type of skin do you have? □Normal □Dry/Dehydrated □Oily □Acne/Acne Prone

Have you ever been under the treatment plan of a: □Dermatologist □Aesthetician

□Plastic Surgeon □Over the counter help If so, were you satisfied with the results? □Yes □No

Have you had Cosmetic Surgery? □Yes □No Type of surgery______________________________

Are you planning to have facial surgery? □Yes □No Facial region:________________________

Any prior cosmetic peels? □ Yes □No Type_____________ ***Any facial scarring?*** □Yes □No

Do you exercise? □ Yes □ No ***Do you use tanning beds?*** □Yes □No ***Do you use sunless tanning agents?*** □ Yes □ No

When was your last sunburn?____________________________________

Ethnicity: □ Caucasian □ Hispanic □ American Indian □ African American □ Asian

Eye Color: □ Blue □ Brown □ Green □ Hazel

Would you say that your skin:

I. Always burns, never tans.
II. Always burns, tans less than average
III. Sometimes burns, tans average
IV. Rarely burns, tans with ease
V. Moderately pigmented, always tans
VI. Deeply pigmented, never tans

Please check the facial skin conditions that apply to you:

__Sun damage __Brown spots __Upper lip lines □ deep □ fine __Freckles __Wrinkles □ deep □ fine

__Blackheads __Whiteheads __Hard bumps under skin __Clogged pores __Excessive oiliness __Acne

__Pimples □ often □ sometimes __Dry patches __Visible exposed blood vessels

Circle how you feel about the overall quality of your skin:

1(bad) 2 3 4 5 6 7 8 9 10 (fantastic)

cont'd

Please check the products you are currently using and list the BRAND NAMES:

□ Cleanser ________________________ □ Soap _________________________

□ Moisturizer______________________ □ Toner________________________

□ Eye Cream_______________________ □ Night Cream___________________

□ Scrub___________________________ □ Astringent_____________________

□ Sunscreen_______________________ □ Mask_________________________

□ Other__________________________

Please check all the treatment services that interest you:

□ Professional Skin Care Program □ Diamond-Tome Microdermabrasion

□ Chemical Peel skin treatments □ Botox/Dysport

□ Collagen Treatments □ Photo Facial Rejuvination

□ Hair Removal □ Acne Treatments

□ Fillers- Restylane/Perlane □ Liposuction Body-jet

□ Laser Skin Resurfacing □ Thermage skin tightening