Aesthetic Interest Questionnaire

NAME: _____ TODAY'S DATE: _____

CONCERNS	
What brought you to the clinic today?	If you could change anything, what would it be?
Which areas would you like to improve? FACE ❑ Fine lines & wrinkles ❑ Sagging facial or neck skin ❑ Submental fullness (double chin) ❑ Facial volume loss (cheeks, under eyes) ❑ Droopy brows/eyelids ❑ Thin lips ❑ Aging mouth/smokers' lines ❑ Sparse eyelashes or brows ❑ Acne ❑ Acne scarring ❑ Enlarged pores ❑ Age spots/brown spots ❑ Facial blemishes/skin tags/milia (bumps) ❑ Facial redness ❑ Broken capillaries or facial veins ❑ Blotchy/uneven skin ❑ Unwanted facial hair ❑ Other _____ ❑ Other _____	BODY ❑ Excess body fat ❑ Lack of muscle tone/definition ❑ Sagging body skin ❑ Spider veins on legs ❑ Nail fungus ❑ Moles and/or skin growths ❑ Surgical/facial scars ❑ Unwanted body hair ❑ Excessive underarm sweating ❑ Unwanted tattoo(s) ❑ Urine leakage with sneeze or cough ❑ Sudden urgency to urinate ❑ Other _____ Would you be interested in a consultation with one of our body specialists? ❑ YES ❑ NO List key areas of interest:
Would you be interested in a make-up consultation? ❑ YES ❑ NO List key areas of interest:	Would you be interested in a skincare product consultation? ❑ YES ❑ NO List key areas of interest:

Today's Date: _____

Rejuvenation Clinic of Sauk Prairie

PATIENT INFORMATION

Name: First Middle Last	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one): Single/ Married/ Divorced / Separated / Widow / Partner	
Street address:	Birth date: / /	Age:	❑ M ❑ F ❑ Other
City:	State:	ZIP Code:	Best Contact: Cell __ Home __ Work __ ( )
Email:			Can we leave a message on best contact #? YES____ NO____
Occupation:	Employer:		Alt. number: Cell __ Home __ Work __ ( )
Emergency contact:	Relationship to patient:		Emergency contact phone: ( )

Referred by:
❑ Health care provider _____
❑Family/Friend_____
❑ Radio_____
❑ Internet (site)_____
❑ Other _____

MEDICAL/SKIN HISTORY

Do you have any of the following-past or present?

❑ High blood pressure
❑ Low blood pressure
❑ High cholesterol
❑ Blood thinners
❑ Phlebitis/blood clots
❑ Other blood disorders (list)
_____
❑ Diabetes
❑ Heart disease/conditions (list)
_____
❑ Pacemaker
❑ Internal defibrillator
❑ Artificial joints/ortho hardware
❑ Metal screws/plates/pins
❑ Are you able to have an MRI?
❑ Yes ❑ No

❑ Excessive hair growth
❑ Ovarian cysts (PCOS)
❑Copper IUD (Paragard)
❑ Anxiety
❑ Depression
❑ Sleep problems
❑ Severe needle phobia
❑ Claustrophobia
❑ Eating disorders
❑ Headaches
❑ Epilepsy/seizures

❑Cold sores/Blisters
❑Past ❑ Present
(Where?) _____

❑ Skin cancer
❑ Melanoma
❑ Basal Cell
❑ Squamous Cell
❑ Actinic keratosis
❑ Skin infections
❑ Other infections (list)
_____
❑ Acne
❑ Eczema
❑ Rosacea
❑ Melasma
❑ Vitiligo
❑ Other skin conditions
_____
❑ Serious injuries
❑ Any cancer (list)

❑ Glaucoma
❑ Diarrhea/Constipation
❑ HIV/AIDS
❑ Hepatitis
❑ Autoimmune diseases (list)
❑ Thyroid (high/low)
❑ Lupus
❑ Scleroderma
❑ Severe allergies
❑ Any other
_____
❑ Other health conditions
_____
❑ Do you leak urine when you cough, sneeze or exercise?
❑ Do you have a sudden urge to urinate?

MEDICATIONS/ALLERGIES

Current medications (please include prescriptions, supplements, vitamins, and over-the-counter products)**:** _____

_____

_____

Do you have any allergies? ❑ Drug (list) _____

❑ Lidocaine ❑ Eggs ❑ Nuts ❑ Other (list) _____

Have you ever had a reaction to: ❑ Cosmetics ❑ Metals ❑ Food ❑ Fragrance ❑ Airborne particles ❑ Preservatives

Do you have food intolerance? ❑ No ❑ Yes (what?) _____

OTHER HEALTH INFO

Current Health Care Provider:

Dermatologist:

How would you describe your overall health? _____

Is your stress level? high medium low

Do you smoke? ❑ No ❑ Yes, Packs per day: _____

Alcohol use? ❑ No ❑ Rarely ❑ 2-3 per week ❑ 2-3 per day ❑ Other_____

Other recreational drugs? ❑ No ❑ Yes, Type: _____

What is your daily intake of water (cups)?

❑ 0-2 ❑ 2-4 ❑ 4-6 ❑ 6-8 ❑ more

How many cups of caffeine do you drink daily?

❑ 0-2 ❑ 2-4 ❑ 4-6 ❑ 6-8 ❑ more

Do you exercise regularly? ❑ Yes ❑ No

If yes, do you cleanse after? ❑ Yes ❑ No

FOR WOMEN:

❑ Oral Contraceptives ❑ No ❑ Yes, Type: _____
❑ Pregnant
❑ Breastfeeding
❑ Hormone imbalances
❑ Menopause/Perimenopause

SKIN HISTORY

Do you cleanse your face?❑ Morning ❑ Evening ❑ Other

How would you describe your skin?

❑ Normal ❑ Dry ❑ Oily ❑ Combination

❑ Sensitive ❑ Sun-Damaged

Do you blush easily? ❑ Yes ❑ No

If yes, what are the contributing factors?

❑ Emotions ❑ Foods/Drinks ❑ Temperature changes

❑ Alcohol ❑ Other

Do you Bruise easily? ❑ Yes ❑ No

Are you taking: ❑ Aspirin ❑ Ibuprofen ❑ Vitamin E ❑ Fish Oil

Do you swell easily? ❑ NO ❑ YES

How does your skin heal?
❑ Average
❑ Fast
❑ Slow
❑ Scar easily
❑ With pigment irregularities
❑ Develops keloids

Under treatment for any current skin condition? ❑ No ❑ Yes

What condition?

Do you wear foundation regularly? ❑ Yes ❑ No

If yes, ❑ Powder ❑ Liquid ❑ Cream

What type of skin care products do you use?

Do you ever experience:
❑ Flakiness ❑ Redness ❑ Tightness
❑ Excessive oily shine

Frequent sun exposure? ❑ Yes ❑ No ❑ Past ❑ Present

Do you use a tanning bed? ❑ Yes ❑ No ❑ Past ❑ Present

Exposure to chemicals, oils, or other caustic substances that may aggravate your skin. ❑ No ❑ Yes (what?)

Past or present use of?

❑ Accutane ❑ Retin-A ❑ Hydroquinone ❑ Topical antibiotics ❑ Oral antibiotics ❑ Differin ❑ Renova ❑ Alpha Hydroxy Acids (AHA's) ❑ Metrogel ❑ Finacea ❑ Any topical prescriptions

For how long?

AESTHETIC HISTORY

Have you ever had these treatments in the past:

❑ Chemical Peels ❑ Microdermabrasion ❑ Dermal Fillers (ex. Juvederm, Restylane, Sculptra) ❑Botox/Dysport ❑ Phototherapy (IPL/BBL)
❑ Laser Peels ❑ Laser Resurfacing (deep peel and/or fractional) ❑ SkinTyte/Thermage/Ultherapy ❑ Kybella ❑ Emsculpt ❑ CoolSculpting
❑ Plastic Surgery (date/type): _____
❑ Other procedures not mentioned (date/type): _____

SIGNATURE

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE (if under 18): _____ DATE: _____

Skin Typing Matrix

Name:_____ **Date:** _____

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

My Ethnic origin is closest to:	Very fair (Celtic and Scandinavian) Fair-skinned Caucasian with light hair and light eyes Pale-skinned Caucasian with dark hair and dark eyes Olive-skinned (Mediterranean, some Asian, some Hispanic) Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans) Very dark-skinned (African)	-- -- -- -- -- --
My eye color is:	Light blue Blue/Green Green/Gray/Golden Hazel/Light Brown Brown	0 1 2 3 4
My natural hair color at age 18 was:	Red Blonde Light brown Dark brown Black	0 1 2 3 4
The color of my skin that is not normally exposed to sun is:	Pink to reddish Very Pale Pale with a beige tan Light brown Medium to dark brown Dark brown to black	0 1 2 3 4 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 Burn, then when burn resolves there is little or no color change Burn, but then turns to tan in a few days Gets pink, but then turns to tan quickly Just tan Just gets darker My skin color is so dark I can't tell	0 1 2 3 4 5 6
When was the last time the area to be treated was exposed to natural sunlight, tanning booths, or artificial tanning cream?	Longer than one month ago Within the past month Within the past two weeks Within the past week	0 1 2 3

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

Total _____

Additional questions:

- **If you sustain an injury to your skin such as a cut, burn or bruise, how long does it take to fully resolve without any discoloration?**_____
- **What happens if you get an insect/mosquito bite? Do you feel you swell more than others?**

  _____