Aesthetics By Eileen
LASER & SKIN CARE MEDICAL SPA

5540 Munford Road, Suite 101
Raleigh, NC 27612
919-881-2100

PATIENT INFORMATION

Name: _____
Last First Middle

Address: _____
Street City State Zip

Phone: home-_____ mobile- _____ work- _____
Leave Message: Yes / No **Wish to receive text updates:** Yes / No **Wish to receive monthly specials:** Yes / No

Email: _____ **Preferred Method of Contact**: _____

Date of Birth: _____/_____/_____ **Age**: _____ **Sex**: _____ **Race**: _____

Marital Status: _____ **Occupation:** _____

Emergency Contact Name: _____**Phone**: _____**Relationship:** _____

How did you hear about us? _____ (*We would like to kindly thank your referral source.)*

1. What is the Main Reason you came in for this consultation? _____

2. What aesthetic treatments and procedures, if any, have you had in the past? _____

3. If you have previously had any aesthetics treatments or procedures, were you pleased with the outcome? Yes / No
If not, in what way were you dissatisfied? _____

4. Do you have any concerns about aesthetic treatments or procedures? Yes / No
If yes, please list your concerns: _____

5. Have you ever had any permanent makeup placement? Yes / No Location on body _____

Aesthetic Products, Treatments, and Procedures

Please let us know which of the following interest you. Please check all that apply.

_____ CoolSculpting/Body Contouring
_____ Skin tightening
_____ Botox®/Dysport®/Xeomin®
_____ Lip Enhancement
_____ IPL/BBL
_____ AHA/Glycolic Peels/Chemical Peels
_____ Skin rejuvenation
_____ Skin discoloration correction (sun damage/spots/melasma)
_____ Skin care products/routine; use of topical Vitamin C
_____ Other area(s) of concern not previously mentioned. Please elaborate:

_____ Cellulite Reduction
_____ Leg/Spider vein treatment
_____ Dermal Fillers
_____ Lash Enhancement
_____ Clear and Brilliant
_____ Hydrafacial
_____ Acne Scarring Repair

_____ Double Chin Reduction
_____ Facial Vein Correction
_____ Permanent Filler
_____ Sunscreen advice
_____ Laser Genesis
_____ Acne Treatment
_____ Microdermabrasion
_____ Hair removal
_____ Vaginal Rejuvenation

Signature: _____ **Date:** _____

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HEALTH HISTORY FORM

Name: _____
Last First Middle

Allergies: (Please list all food and drug allergies, including reaction.) _____

Medications: (Please list all current medications, including over-the-counter and homeopathic.) _____

_____

_____

Pregnant/Nursing: Yes / No **Tobacco use:** Yes / No **Average daily alcohol consumption:** _____

History of adverse reaction to topical anesthesia: Yes/No

Surgical History: (Please list all prior surgical procedures, including cosmetic surgery.) _____

_____

_____

Past Hospitalizations: _____

Medical History: (Please check any of the following diagnoses that apply to you.)

- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Diabetes mellitus
- ☐ Liver disease, hepatitis or jaundice
- ☐ Chronic headache
- ☐ Leg, back, neck pain
- ☐ Fainting/lightheadedness
- ☐ Glaucoma/eye surgery
- ☐ Cancer (type)_____
- ☐ Bleeding disorder
- ☐ Autoimmune disease
- ☐ Seizures
- ☐ Kidney problems
- ☐ Skin disorders
- ☐ History of Scarlet/Rheumatic fever
- ☐ Keloid scars
- ☐ Blood clots
- ☐ Stomach/intestinal problems
- ☐ Emotional/psychiatric concerns

Family History: (Please list any family history of significant illness.) _____

Other helpful information: (Please elaborate on any personal or medical information that may help us to provide you the best care possible.) _____

SIGNATURE: _____ **DATE:** _____

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Patient Name:_____**Date of Birth:**_____

Fitzpatrick Classification Questionnaire

SCORE		0	1	2	3	4
	What is the natural color of your hair?	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black
	What is the eye color?	Light blue, Gray, Green	Blue, Gray, Green	Blue	Dark Brown	Brownish Black
	What is the color of sun unexposed skin areas?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	How many freckles on unexposed skin areas?	Many	Several	Few	Incidental	None
	What happens when you are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
	How well do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 month ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	TOTAL					

- 00-07 points = Skin type I
- 08-16 points = Skin type II
- 17-25 points = Skin type III
- 25-30 points = Skin type IV
- 30-40 points = Skin type V & VI

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Patient Name:_____ DOB:_____

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Aesthetics by Eileen at Laser & Skin Care Medical Spa's, PLLC Notice of Privacy Practices. This notice describes how Aesthetics by Eileen at Laser & Skin Care Medical Spa, PLLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. _____
Initial

Credit Card HIPAA Release

Aesthetics by Eileen at laser & Skin Care Medical Spa, PLLC require a signed release statement, from you, when a credit card is used to pay for a procedure. If there is ever a dispute with the credit card company regarding this transaction, they we need to have the ability to provide personal information to THAT bank or credit organization.

We value your privacy and promise that the associates of Aesthetics by Eileen at Laser & Skin Care Medical Spa, PLLC, will provide NO protected health information to the credit card company unless those details are necessary to resolve a dispute.

Thank you for acknowledging notice of our Privacy and Credit Card practices.

_____
Initial

_____ _____
Patient Signature Date