# Medical Intake Form

Name _____ Birthday _____

Phone _____ Email _____

Do we have permission to show your photos for educational and marketing purposes? ☐ Yes ☐ No

What concerns do you have about the overall appearance of your skin? (Circle all that apply)

Acne Acne scarring Age spots

Blackheads Broken Blood Vessels Bumps on arms Cysts/Nodules

Dehydrated Skin Dull Complexion Excessive Facial Hair Facial Veins

Fine Lines/Wrinkles Frequent Breakouts Large Pores Melasma

Oily Skin PIH Redness Rosacea Rough/ Uneven Texture Sun Damage

How would you describe your skin?

Oily Dry Combination Sensitive Reactive

How would you describe your stress level?

Low Moderate High Severe

Are you currently under the care of a physician? ☐ Yes ☐ No

Do you have any allergies to food or medications? ☐ Yes ☐ No

Are you currently on any medications either topical or oral? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you prone to cold sores? ☐ Yes ☐ No

If yes, do you have a prescription for Valtrex or similar medications? ☐ Yes ☐ No

Do you have an allergy to Latex? ☐ Yes ☐ No

Do you tan in the sun or tanning bed/booth? ☐ Yes ☐ No

Please circle the skincare products you are currently using:

Cleanser Toner Serum Scrub Mask

Self Tanner Makeup /Other

The answers I have provided are true and correct to the best of my knowledge

Client Signature Date

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