Parker Aesthetics, LLC
Medical Aesthetics

Date______________________

Name: ____ Age: __________

Date of Birth: __________________

Address: ____

City____State___________Zip_____________________

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*Please circle the best phone number we can contact you at regarding your treatment (<u>please use a phone number where messages with private information can be recorded</u>)

Telephone: Home ______________________ Work _____________________Cell__________________

Employer: ____

Occupation: ____

E-mail: ____

Referred by: ____

Emergency Contact____________________________________Phone______________________________________

Would you like to receive emails on special promotions? YES_______NO_______

Have you been under the care of a physician or other medical professional, including any surgery, within the past year? YES_________NO_________

If yes, please explain: ____

____

Do you have any drug allergies? YES_______NO_______

If yes please explain____

Do you or ever have you had an allergic reaction to any chemicals or drugs? YES______ NO______

If yes, please explain____

Latex Allergy? YES______NO______

List any medications you take: ____

____

List any vitamin supplements you take:____

____

In the last 3 months have you used any of the following products: Glycolic acid or other alpha hydroxy or beta hydroxy acid products, exfoliating or resurfacing products or treatments? YES________NO________

Do you get herpes/cold sores? YES _______ NO______ If so, how frequent______________________________________

Are you pregnant or lactating? _______

Have you been diagnosed with Polycystic Ovarian Disorder (POS)? YES______NO___________

Do you get epileptic seizures? YES_______NO________

Have you had skin cancer? YES_______ NO_______ If yes, which type_____________________
If yes, where on the body? ____

Have you been on Accutane? YES_______ NO______ If yes, approximate date finished___________

Are you on Coumadin or other blood thinners? YES______NO______

Do you have a fear of needles? YES_______NO _______

Do you form thick/raised (keloid) scars? YES________NO________

Are you a diabetic? YES___________NO___________
List daily ounces of consumption: Water: ___________ Caffeine: ___________ Alcohol: __________
Do you smoke? Cigarettes? YES________NO_______
Daily recreational drug use? YES________NO________

How frequently are you exposed to the sun? Infrequently Frequently Regularly
How frequently do you use a tanning bed? Infrequently Frequently Regularly

Have you had any cosmetic procedures in the past 6 months? YES______ NO______
Please list____

Have you ever had an adverse reaction after using any skin care product? YES_______NO______
If YES, describe: ____
Would you say your skin is sensitive? YES________NO________
If yes, please describe: ____

What do you see in the morning in the mirror that you DO NOT like? ______________________________________

____

Do you have any concerning skin problems or specific issues pertaining to your face or body?

____

SKIN EVALUATION

Are you currently pleased with your skin and skincare? YES________NO_______

Are you interested in **complimentary** (absolutely NO obligation) Epionce skincare samples? YES________NO________

How would you describe your skin type? (circle all that apply)

Normal Dry Oily Combination Acne Prone Active Acne

How would you describe your skin color? (circle the best choice)

I Creamy Complexion Always burns easily, never tans

II Light Complexion Always burns, tans slightly

III Light/Matte Complexion Burns moderately, tans gradually

IV Matte Complexion Seldom burns, always tans well

V Brown/Black Complexion Rarely burns, deep tan

Please list the products you are currently using and their Brand Names:

Morning Evening

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from the treatment received. I am aware that it is my responsibility to inform Rebecca Porter, Parker Aesthetics, staff and practitioners of my current medical or health conditions and to update this information.

PRINT NAME____

Signature____

Reviewed by____