Euphoria

SkinCare S T U D I O

PATIENT INFORMATION RECORD

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Name:______________________________ Today's Date_________________________

Date of Birth:______________ Gender: ☐ Male ☐ Female

Home Address______________________________ City__________________________

State: _________ Zip Code: _______ Phone: __________________ Home - Work or Cell?

We like to send Appointment Reminders to our customers, There are three ways our system can do this. Please choose how you would like us to send your appointment reminder to you.

E-Mail :____

Please provide your E-Mail address

Text Message, Cell # (_____)_____-_____________ Mobil Carrier_____________________

Please provide cell phone # and your service provider (i,e,) Verizon, AT&T, T-mobil ect.

Personal Phone call : ____

Please provide phone #

Emergency Contact Name and Phone____

How were you referred to us?____

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

HISTORY

Ethnic Background

□ Caucasian □ Hispanic □ Asian □ African American □ Native American □ Other

Skin History

□ Cosmetic Surgery □ Botox Injections □ Fillers □ Skin Cancer □ Dermatitis

□ Keloid Scarring □ Laser Resurfacing □ Chemical Peels

Other (specify) ________________

Which conditions do you want to improve?

□ Hyperpigmentation (Brown Spots) □ Acne □ Acne □ Scarring □ Sun Damage

□Enlarged Pores □ Fine Lines & Wrinkles □ Age Spots □ Surgical Facial Scars

Are you using any skin lighteners?
□Yes □ No

Do you use Sun protection?
□Yes □ No - what type? ___________

Do you sunbathe or participate in outdoor activities? □Yes □ No

Do you smoke? □Yes □ No **Do you exercise?** □Yes □ No

Have you ever had laser hair removal? □Yes □No

Have you used any of the following hair removal methods in the past six weeks?

□Shaving □Waxing □Electrolysis □Plucking □Tweezing □Stringing □Depilatories

Have you had permanent cosmetics? □Yes □No If yes, what area? ________________

MEDICAL HISTORY

Are you currently under the care of a physician? □Yes □ No
If yes, for what:____

Are you currently under the care of a dermatologist? □Yes □No
If yes, for what:____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? □Yes □No
Do you have any of the following medical conditions? (Please check all that apply)
□Cancer □Diabetes □High blood pressure □Herpes □Arthritis □Frequent cold sores
□HIV/AIDS □Keloid scarring □Skin disease/Skin lesions □Seizure disorder □Hepatitis
□Hormone imbalance □Thyroid imbalance □Blood clotting abnormalities □Any active infection

LIST ALL ALLERGIES YOU MAY HAVE REACTIONS TO.
(ie Milk, Nuts, Food Allergies, Medications, Latex ect)

____

____

MEDICATIONS

What oral medications are you presently taking? □Birth control pills □Hormones
□Others (Please list):____

Are you on any mood altering or anti-depression
medication?____

Have you ever used Accutane? □Yes □No If yes, when did you last use it?
____
What topical medications or creams are you currently using? □ RetinA , □Others (Please list):
____

For our female clients:

Are you pregnant or trying to become pregnant? □Yes □No
Are you breastfeeding? □Yes □No
Are you using contraception? □Yes □No

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I acknowledge that all information contributed by me is accurate to the best of my knowledge, and that the present condition of the areas to be treated are as stated on this record. I understand that repeated treatments are necessary for results. If I am unable to keep my appointment, I wll give at least a 24 hour notice. If I do not, I will be charged for the timereserved. Payment is required at the time of service. Your signature below indicates you are financially responsible for all charges incurred, that you understand unpaid balances over 60 days will be assessed 1% compounded monthly interest unless other arrangements have been made, and that outstanding balances over 90 days will be processed by a Collection Agency.Personal checks are accepted. If any check is returned a $35.00 returned check fee will be applied and collected. After 30 days 5% interest will be added, and after 90 the account will be handed over to collections.

Signature of Patient or Legal Guardian

X____Todays Date: ________ 20 _____