|  |  |
| --- | --- |
|  | 6051 N Eagle RdBoise, ID 83713208-939-6227 |

**AESTHETIC PATIENT INFORMATION**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

 (FIRST) (MI) (LAST)

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (STREET) (CITY) (STATE) (ZIP)

**Home Phone:** (\_\_\_\_) \_\_\_\_\_\_\_­\_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_­\_\_\_\_\_\_\_\_\_ ext: \_\_\_\_\_­ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_

May we leave a voicemail? □ Yes □ No ­­­ Preferred Message Phone: □ Home □ Work □ Cell

**Provide your email address for appt reminder/upcoming events/promotional info:**

**Marital Status:** □ Single □ Married □ Divorced □ Widow Gender: □ Male □ Female

**Emergency Contact:**

Relationship to the patient: □ Spouse □ Parent □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)

**How did you hear about us?** □ Family/Friend □ Physician □ Insurance □ Our Website □ Demand Force □ Radio

□ Internet/Search Engine □ Magazine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other

**MEDICAL HISTORY (please circle all that apply)**

|  |  |  |
| --- | --- | --- |
| AnxietyArthritisAsthmaAtrial FibrillationBenign Prostatic HypertrophyBone Marrow TransplantationBreast CancerColon CancerCOPDCoronary Artery Disease |  Depression Diabetes End Stage Renal Disease GERD *(Reflux Disease)* Hearing Loss Hepatitis Hypertension *(High Blood Pressure)* HIV/AIDS Hypercholesterolemia Hyperthyroidism *(High)* |  Hypothyroidism *(Low)* Leukemia Lung Cancer Lymphoma Prostate Cancer Radiation Treatment Seizures Stroke NONE / Other  |

**SURGICAL HISTORY (please circle all that apply)**

|  |  |  |
| --- | --- | --- |
| Appendix RemovalBladder RemovedMastectomy (Right, Left, Bilateral)Lumpectomy (Right, Left, Bilateral)Breast BiopsyBreast ReductionBreast ImplantsColectomy: Colon Cancer ResectionColectomy: DiverticulitisColectomy: IBDGallbladder RemovedHeart: Coronary Artery Bypass Heart: PTCA *(Angioplasty/Stent)* | Heart: Mechanical Valve ReplacementHeart: Biological Valve ReplacementHeart: Heart TransplantJoint Replacement, Knee (Right, Left, Bilateral)Joint Replacement, Hip (Right, Left, Bilateral)Kidney BiopsyKidney Removed (Right, Left)Kidney Stone RemovedKidney TransplantOvaries RemovedOvaries: EndometriosisOvaries Removed: CystOvaries Removed: Ovarian Cancer |  Prostate Removal: Prostate Cancer Prostate Biopsy Prostate: TURP Skin Biopsy Skin: Basal Cell Cancer Surgery Skin: Squamous Cell Cancer Surgery Skin: Melanoma Surgery Spleen Removed Testicles Removed Hysterectomy: Fibroids Hysterectomy: Uterine Cancer Hysterectomy NONE / Other  |

**SKIN HISTORY (please circle all that apply)**

|  |  |  |
| --- | --- | --- |
| AcneActinic Keratosis | Dry SkinEczema | Poison IvyPrecancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever/Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | NONE / Other  |

**Do you wear Sunscreen?** □ Yes □ No; If yes, what SPF level: \_\_\_\_\_ **Do you tan in a tanning salon?** □ Yes □ No

Do you sunburn easy? □ Yes □ No **Do you have a family history of Melanoma?** □ Yes □ No

Do you have acne breakouts? □ Yes □ No, please describe

Are you using or have you ever used any acne products/Retinoids/medications? □ Yes □ No

If yes, what product and date of last treatment?

Have you ever had a chemical peel, laser, microdermabrasion or any skin resurfacing treatments? □ Yes □ No

If yes, what was performed and date of last treatment?

Do you have regular collagen, Botox or other dermal filler injections? □ Yes □ No

If yes, what was performed and date of last treatment?

***Continued on Back 🡪***

Do you have any specific skin care problems?

Do you develop cold sores/fever blisters? □ Yes □ No, last breakout

Do you currently use or receive depilatories or waxing? □ Yes □ No, what type

Are you currently pregnant or lactating, or trying to become pregnant? □ Yes □ No

Do you wear contact lenses? □ Yes □ No Do you have Permanent makeup? □ Yes □ No

**Ethnic Skin Type:** □ Caucasian □ African American □ Hispanic □ Asian □ Eastern Indian □ American Indian

Do you consider your skin to be: □ Sensitive □ Resilient □ Unsure □ Oily □ Dry □ Combination □ Hydrated

Natural eye color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Natural hair color?

What is your skin care regimen?

What are your skin care goals?

|  |
| --- |
| **Please check any other concerns you may be interested in listed below:** |

|  |  |  |
| --- | --- | --- |
| □ Skin care advice□ Skin care products□ Chemical Peel□ Facial redness□ Brown spots/age spots/freckles/blotchy□ Length/fullness/darkness of eyelashes | □ Facial contouring□ Facial Injectables/fillers□ Facial fine lines/wrinkles□ Thin lips□ Nose shape/size□ Drooping eyelids | □ Body Contouring□ Neck wrinkles□ Unwanted hair□ Facial veins□ Facial fullness/drooping□ Drooping brows |

|  |
| --- |
| **MEDICATIONS & SUPPLEMENTS** |

|  |
| --- |
| **MEDICATION ALLERGIES, ALLERGIES or SENSITIVITIES** |

|  |
| --- |
| **SOCIAL HISTORY (please circle all that apply)** |

**Alcohol Use**: □ less than 1 drink per day □ 1-2 drinks per day □ 3 or more drinks per day □ NONE

**Caffeine Use**: □ Several times a day □ Once a day □ A few times a week □ A few times a month □ NEVER

**Illicit / illegal Drug Use**: □ IV Drug use □ Drug use

**Cigarette Smoking**: □ Current every day smoker □ Current some day smoker □ Former smoker □ Never smoker

**How often do you exercise?** □ Several times daily □ Once daily □ few times a week □ few times a month □ Never

**Occupation/Workplace** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Notice of Privacy Practices**: As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by Keller Skin Care.

I certify the above information is correct to the best of my knowledge.

**Signature of Patient/Legal Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_