|  |  |
| --- | --- |
|  | 6051 N Eagle Rd  Boise, ID 83713  208-939-6227 |

**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)**

|  |  |  |
| --- | --- | --- |
| Anxiety  Arthritis  Asthma  Atrial Fibrillation  Benign Prostatic Hypertrophy  Bone Marrow Transplantation  Breast Cancer  Colon Cancer  COPD  Coronary 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 Removal  Bladder Removed  Mastectomy (Right, Left, Bilateral)  Lumpectomy (Right, Left, Bilateral)  Breast Biopsy  Breast Reduction  Breast Implants  Colectomy: Colon Cancer Resection  Colectomy: Diverticulitis  Colectomy: IBD  Gallbladder Removed  Heart: Coronary Artery Bypass  Heart: PTCA *(Angioplasty/Stent)* | Heart: Mechanical Valve Replacement  Heart: Biological Valve Replacement  Heart: Heart Transplant  Joint Replacement, Knee (Right, Left, Bilateral)  Joint Replacement, Hip (Right, Left, Bilateral)  Kidney Biopsy  Kidney Removed (Right, Left)  Kidney Stone Removed  Kidney Transplant  Ovaries Removed  Ovaries: Endometriosis  Ovaries Removed: Cyst  Ovaries 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)**

|  |  |  |
| --- | --- | --- |
| Acne  Actinic Keratosis | Dry Skin  Eczema | Poison Ivy  Precancerous 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_