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Kp Aesthetics
Cosmetic Medicine

PATIENT INFORMATION

Patient Name _____ DOB_____
Address _____
City _____ State _____ Zip _____
Primary Contact Number (_____) _____(H) (C) (W)
Cell Phone Carrier (for appointment reminders, etc.)_____
Sex: M ___ F___

Occupation___ _____Employer_____
Email Address:_____
Would you like to receive emails for promotional events, discounts, and specials ? (Y) __ (N)__
Please Note: Your email address is used strictly for our communication with you and will not be given out.

Emergency Contact _____Relation_____
Phone (_____) _____

How did you hear about us?_____

HEALTH INFORMATION

Do you have any allergies to medications? (Y) ___ (N)____ If yes, please specify and state type of reactions:
_____
_____
Are you allergic to any cosmetic ingredients or foods? (Y) __ (N) __
If yes, please list:
_____
_____
Do you have allergies to latex? (Y) ____ (N) ____
Do you have any neuromuscular or autoimmune diseases? (Y) __ (N) __
List: _____
_____

Are you pregnant/ trying to become pregnant?_____
Do you use oral contraceptives? _____

Do you smoke? (Y)____ (N) ____
If yes, how many per day _____ How many years _____
Do you drink alcohol? (Y) ____ (N) ____

If yes, how much _____ How often _____

Do you take Aspirin, Advil, Motrin, Ibuprofen, fish oil, anti-coagulant (blood thinning) or anti-inflammatory meds more than once a week? (Y) __ (N) __ If yes, please explain:

_____

_____

List all medications you are taking (prescription and over the counter):

_____

_____

Have you had any cosmetic procedures in the past? Please list:

_____

_____

Please list all surgeries or hospitalizations with dates:

_____

_____

Have you ever had any of the following (please circle):

Anemia	Heart valve replacement	Multiple Sclerosis
Anxiety	Hepatitis	Muscular dystrophy
Arthritis	Hemoglobinuria	MVP (heart valve problem)
Asthma	High blood pressure	Open Infected wound
Autoimmune disorder	HIV	Paroxysmal cold
Blood disorder	Hormonal problems	Pregnancy
Bruise easily	Impaired circulation	Raynaud's disease
Chest pain	Impaired skin sensation	Rheumatic fever
Clotting disorder	Intestinal problems	Seizures
Depression	Irregular heart beat	Shortness of breath
Diabetes	Keloids (scars)	Skin cancer
Excessive bleeding	Kidney disease	Stroke
Excessive scarring	Lung disease	Stomach problems
Heart attack	Liver disease	Thyroid disorder
Heart failure	Low Blood Pressure	
Heart valve disease	Migraines	

Other:_____

Cancer: (Please list type)

_____

Do you have any metallic implants? Yes_____ No_____ If yes, where are they located?

_____

PERSONAL CONCERNS:

Which concerns apply to you? Please circle all that apply:

Excessive oiliness	Unwanted hair
Stretch marks	Varicose Veins
Uneven skin tone	Wrinkles
Clogged pores	Black or Whiteheads
Scarring	Dry patches

Unwanted body fat	Stress Incontinence
Visible exposed blood vessels	Labial Tightening
Vaginal laxity	Brown spots (hyper-pigmentation)
Vaginal Wall Thinning	Enlarged pores
Vaginal Dryness	Spider veins

Other: _____

*Are you interested in having a free consult with one of our certified CoolSculpting specialists?
YES NO

What is your skin type: Dry _____ Oily _____ Normal _____ Combination _____
Are you using any topical creams or lotions, oral antibiotics for acne?
_____

Please complete this section for <u>INJECTABLES ONLY</u>:
Have you ever had any of the following Injectables or implants: (please circle)

Botox	Radiesse	Hylaform
Dysport	Voluma	Belotero
Xeomin	Silicone	BellaFill (Artefill)
Juvederm	Collagen	

Other: _____
If so, when was it done _____
What area(s) _____

Do you have any of the following chronic skin disorders?
Psoriasis _____ Dermatitis _____ Eczema _____ Keloid Scarring ____
Cold Sores ____ Sun Blisters ____ Fever Blisters ____ Herpes Simplex/Blisters ____

Have you ever undergone any of the following treatments?
Microdermabrasion ____ Acid Peel ___

<u>ALL CLIENTS/ ALL SERVICES:</u>

Are you currently/ Have you ever used **Acutane**? YES NO
If so, when?_____

I consent to taking photographs and authorize their anonymous use for the purposes of medical audit, education, promotion and marketing. _____ initial.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this form. _____ initial.

PATIENT'S SIGNATURE:
To the best of my knowledge, the information provided above is true and accurate.
Patient Signature
_____Date_____

Provider Signature_____Date_____