Kp Aesthetics
Cosmetic Medicine

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PATIENT INFORMATION

Patient Name _____ DOB_____
Address _____
City _____ State _____ Zip _____
Primary contact number (_____) _____(H) (C) (W)
Sex: M ___ F___
Marital Status: S ___ M ___ W ___ D ___
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?_____
*A $25 credit is added to your account for each friend or family member you refer to our practice.

HEALTH INFORMATION

Current Weight: _____lbs Height: _____
OFFICE USE – BMI: _____

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 or 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)

_____

Is your general health good? Yes ____ No ____
Date of last physical _____
Name of family physician_____

Please complete this section if you are interested in: INJECTABLES or SKIN CARE

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

Excessive oiliness
Stretch marks
Uneven skin tone
White spots (hypopigmentation)
Clogged pores
Scarring
Upper lip lines
Varicose Veins
Other:

Wrinkles
Black or Whiteheads
Dry patches
Unwanted body fat
Visible exposed blood vessels
Brown spots (hyperpigmentation)
Enlarged pores
Spider veins

_____

What is your skin type: Dry _____ Oily _____ Normal _____ Combination _____
Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation: Please list:

_____
_____
_____

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

Botox
Dysport
Xeomin
Juvederm

Radiesse
Parlance
Silicone
Collagen

Hylaform
Belotero
BellaFill (Artefill)

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

Please list the cosmetic products and BRAND NAMES you currently use:
Cleanser _____
Moisturizer _____
Toner _____
Mask _____
Eye Cream _____
Salicylic Wash/Cleanser _____
Vitamin A/Retinol _____
Alpha/Beta Hydroxy Cream _____
Other _____

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 ___ Cosmetic Surgery ___ Accutane _____

If so, when was it done? _____ What
area(s)_____ What type of laser equipment was used?
_____

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