



PACIFIC AESTHETIC INSTITUTE

New Patient Registration

Today's Date:		Social Security Number:	
Name: <i>Last</i>	<i>First</i>	<i>Middle</i>	
How do you like to be addressed:		Date of Birth:	
Address: <i>Street</i>			
<i>City</i>	<i>State</i>	<i>Zip</i>	
Email Address:			
Preferred Contact Number: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<i>Cell Phone:</i>	
<i>Home Phone:</i>		<i>Work Phone:</i>	

Reason for today's visit: <input type="checkbox"/> Botox <input type="checkbox"/> Fillers <input type="checkbox"/> Facials <input type="checkbox"/> Skincare <input type="checkbox"/> IPL/Lasers <input type="checkbox"/> Surgical Consultation
<input type="checkbox"/> Other
How did you hear about us? <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> Radio <input type="checkbox"/> Print Media
If you were referred by a person, who may be thank for the referral?
Name: <i>Last</i> <i>First</i> <i>Middle</i>

Please provide a copy of your driver's license for our records.

MEDICAL SKINCARE ASSESSMENT

(SAMPLE)

PATIENT'S NAME _____ Today's Date _____

Date of Birth _____ Do you wear contact lenses? Yes No

PERSONAL HISTORY

Are you currently seeing a physician for any reason? Yes No

If yes, explain reason _____

Have you ever seen a physician or technician specifically for a skin problem or skincare? Yes No

If yes, when and for what reason? _____

Are you currently under any other physician's or technician's care for your skin? Yes No

If yes, detail reason(s) _____

Have you or any family member ever had a skin lesion removed by a physician? Yes No

If yes, who had lesion removed? _____ Anatomical location of lesion? _____

Do you have any health problems? Yes No If yes, list _____

Do you have any allergies or skin sensitivities? Yes No

If yes, list all allergies/skin sensitivities _____

Do you currently take any oral medications (prescriptive pharmaceuticals)? Yes No

(include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension etc.)

If yes, list all oral medications _____

Do you use any topical medications (prescriptive pharmaceuticals)?

(includes Retin-A®, Hydroquinone, Accutane®, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)

If yes, list all topical medications _____

Have you ever taken Accutane®? Yes No

I currently take Accutane: Dosage prescribed _____ Frequency taken _____

I took Accutane in the past:: Date discontinued _____ Dosage/frequency used _____

Have you ever had a "COLD SORE"? Yes No If yes, when was your last cold sore? _____

Do you ever use depilatories or waxes on your face? Yes No If yes, when last used? _____

Do you smoke? Yes No If yes, how much/often? _____

Do you consume alcohol? Yes No If yes, frequency/amount _____

Do you have a healthy diet? Yes No List any dietary concerns _____

Do you exercise? Yes No If yes, how often? _____ Type(s) _____

Do you take vitamins? Yes No If yes, what type(s)? _____

Do you drink water? Yes No If yes, how many glasses per day? _____

For women only:

Do you have regular periods? Yes No

Are you going through menopause? Yes No

Are you trying to become pregnant? Yes No Are you in a fertility program? Yes No

Are you pregnant or lactating? Yes No Have you ever been pregnant? Yes No

If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? Yes No

SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen? Yes No

If yes, list products used _____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Yes No

If yes, explain type(s) of exfoliation _____

SKIN PROCEDURE HISTORY

Have you previously had any of these skin procedures (treatments)? Yes No If no, skip this section.
Microdermabrasion Yes No Date of last procedure
Chemical Peel(s) Yes No Type of procedure(s)/date
Phototherapy Yes No Type of procedure(s)/date
Laser Resurfacing Yes No Type of procedure(s)/date
Radiofrequency Yes No Type of procedure(s)/date
Dermabrasion Yes No Type of procedure(s)/date
Facial Surgery Yes No Type of surgery(s)/date
Other procedures/date?
Additional comments about above procedure(s)

OILY SKIN OR ACNE

Any acne breakout? Blackheads Whiteheads Enlarged Pores Pustules Large pores Cysts
Do you have any history of acne or periodic breakout? Yes No If yes: Now? In past?
Do you only experience breakout during or around your menstrual cycle? Yes No
Do you always have a pimple or some type of breakout? Yes No
Does your skin ever flake or feel tight and dry? Frequently? Occasionally? Very rarely?
Is your skin ever shiny (oily) a few hours after cleansing? Frequently? Occasionally? Very rarely?
How noticeable are your pores? Very? T-zone only? Not very noticeable?

SENSITIVE AND INTOLERANT OR DRY SKIN

Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc.? Yes No
Does your skin ever get flaky or itch? Yes No If yes, is it seasonal or all the time?
Have you ever been diagnosed with Rosacea? Yes No If yes, when was the diagnosis made?
Do you have difficulty healing from a cut or burn? Yes No If yes, explain
Have you ever had keloid scarring? If yes, explain

PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

Do you have facial wrinkles? Deep wrinkles Crows feet Fine lines Skin Laxity
Have you been treated with: Botox? Fillers? If yes, date of last treatment
Do you work inside? Yes No Occupation
Are your hobbies done mostly outside? Yes No Hobbies
In the past (including childhood) did you live in a sun belt? Yes No If yes, where?
In the past have you neglected to use a sunscreen when outdoors? Yes No
Do you ever use tanning beds? Yes No If yes, when?
Do you currently wear a sun protection product all day, everyday? Yes No
Are you willing to wear a sun protection product all day, everyday? Yes No

Fitzpatrick Scale (how your skin reacts to sun exposure). How do you tan?

- I Burn II Usually Burn III Sometimes Burn
IV Rarely Burn V Never Burn-"Brown" VI Never Burn-"Black"

Is your skin pigmentation (skin discoloration): Even Uneven Birthmark(s) Pregnancy Mask
What is your Ethnicity and Race (heritage)?

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

- 1.
2.

WHAT SPECIFIC SKIN AREAS DO YOU WANT TO TREAT?

Face Neck Chest Back Other

Table with 2 columns: Signature (Patient, Technician, M.D.) and Date.

MEDICAL SKINCARE INFORMED CONSENT

(SAMPLE)

NAME _____ Today's Date _____ Date of Birth _____

The SkinCeuticals Pigment Balancing Peel, Micropeel Plus or MicroPeel® [hereinafter known as "Clinical Procedure(s)"] is not a cure all epidermal treatment. However, for certain skin conditions, these Clinical Procedure(s) can provide marked improvement in the appearance of one's skin. Therefore, it is very important that you have a thorough understanding of what a Clinical Procedure(s) can and cannot do for your particular skin condition. In addition, it is imperative that you acknowledge the potential risks associated with the administration of Clinical Procedure(s).

The foregoing list is not intended to be a complete or exhaustive list of all possible problems or complications, which may arise as a result of the Clinical Procedure(s). Should one or more of the foregoing complications arise, please *notify the physician's office immediately*.

Discomfort is generally minimal and subsides after a short duration.

Swelling is unusual. If it occurs, it is minimal. Swelling subsides in a few hours to a few days.

Reddening or a red discoloration may persist anywhere from a few minutes to several days.

Demarcation is a difference in color, texture, or pigmentation that may occur at the junction between the treated and non-treated skin areas. This is unusual with epidermal procedures.

Existing Blemishes or moles, blood vessels (telangiectasias), freckles and sun spots may become more obvious and darker since layers of dead skin have been removed.

Eye Injury caused by chemicals getting into the eye, scarring and vision disturbances may occur. Protective safety goggles are recommended to be worn by you, the patient, while chemicals are being used during all Clinical Procedure(s).

Scarring is very unusual, but may occur.

Pigmentation is rare and usually temporary. Possible permanent changes in the color of the skin could occur.

Milia may occur, but will usually disappear quickly.

Infection is extremely unlikely, but may happen. An outbreak of herpes may occur in effected individuals (if you are prone to cold sores, ask your physician for medication).

Hair Growth: If the dermaplaning phase of the Biomedic MicroPeel is administered, hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter the normal hair growth pattern and cause a darker and denser restoration process.

In General: Any and all risks and complications can result in additional surgery, hospitalization, time off work and expenses to you. Early detection and treatment may minimize future complications.

Before subjecting yourself to any Clinical Procedure(s), read carefully the following statements. After you have read each statement, please **initial** each respective statement in the space that has been provided.

_____ The Clinical Procedure(s) has been explained to me in detail by the physician and/or members of the physician's staff and that for optimum results, a Home Treatment Product Program is needed to enhance the results of Clinical Procedure(s).

_____ I understand that a Clinical Procedure(s) is a skin rejuvenation treatment. I may need several administrations of the Clinical Procedure(s) in order to achieve my best results.

_____ I understand that Clinical Procedure(s) need not be administered by a physician. It is also my understanding that, in addition to receiving formal training, any non-physician medical assistant (i.e., RN, LPN, Surgical Technician, Cosmetologist or Aesthetician) who administers Clinical Procedure(s) has had their skills reviewed and endorsed by the supervising or attending physician.

_____ I understand that it is extremely important to strictly follow all Home Care instructions when striving for optimal results.

_____ I understand that if I experience any adverse side effects that appear to be attributable to my use of Home Care products, I would discontinue use of the products and notify the office.

I certify that I have read and understand **ALL** of the above. I have also discussed the same with _____, MD and _____, Skincare Technician

Patient Signature:

Date: ____/____/20____

I certify that I have discussed **ALL** of the above with the patient and have offered to answer any questions regarding the Clinical Procedure(s), and I believe that the patient fully understands the explanations and answers.

Physician Signature:

Date: ____/____/20____

Skincare Technician or Witness Signature: _____

Date: ____/____/20____

Fitzpatrick Classification Questionnaire

SCORE		0	1	2	3	4
	What is the natural color of your hair?	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black
	What is the eye color?	Light blue, Gray, Green	Blue, Gray, Green	Blue	Dark Brown	Brownish Black
	What is the color of sun unexposed skin areas?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	How many freckles on unexposed skin areas?	Many	Several	Few	Incidental	None
	What happens when you are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
	How well do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 month ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	TOTAL					

- 00-07 points = Skin type I
- 08-16 points = Skin type II
- 17-25 points = Skin type III
- 25-30 points = Skin type IV
- 30-40 points = Skin type V & VI