



Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Circle One: Male or Female

Social Security Number: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Occupation: _____ Employer: _____

Reason for today's visit: _____

Do you have any known allergies? _____

Please list any medications, including prescription and/or over the counter medicines you are presently taking (oral and topical): _____

Please list any past/present medical conditions or surgeries: _____

Please list previous types of hair removal used for the area(s) you want treated (i.e. waxing, electrolysis, shaving, depilatories, laser, etc.): _____

When: _____

List previous types of laser procedures (i.e. photofacial, vein, hair removal, acne, rosacea, hyperpigmentation, etc.): _____

When: _____

List previous types of cosmetic procedures (i.e. chemical peel, microdermabrasion, Botox, collagen injections, sclerotherapy, micropigmentation-permanent-make-up, etc.) _____

Rejueva'

Please circle yes or no:

- Yes No 1. Do you have cold sores? If yes, when was the last? _____
- Yes No 2. Do you have HIV?
- Yes No 3. Do you have keloid formation or scars that haven't healed smoothly?
- Yes No 4. Do you have any skin disorders i.e. psoriasis, vitiligo, skin cancer, etc.?
- Yes No 5. Are you diabetic?
- Yes No 6. Do you have hepatitis?
- Yes No 7. Are you or could you be pregnant?
- Yes No 8. Do you have any endocrine disorders?
- Yes No 9. Do you have polycystic ovarian disease?
- Yes No 10. Do you have heart disease?
- Yes No 11. Do you have lung disease?
- Yes No 12. Do you have high blood pressure?
- Yes No 13. Do you take any medications that cause photosensitivity?
- Yes No 14. Do you have any clotting problems?
- Yes No 15. Have you ever had a DVT (deep vein thrombosis)?
- Yes No 16. Do you have a tattoo(s) in the area(s) that you want treated?
- Yes No 17. Have you sunbathed or been in a tanning bed within the last 30 days?
- Yes No 18. Have you ever been diagnosed with glaucoma?

Which of the following best describes your skin type? Circle one:

- 1. Always burn, never tan
- 2. Always burn, sometimes tan
- 3. Sometimes burn, tan with ease
- 4. Rarely burn, tan with ease
- 5. Moderately pigmented, never burn

Describe your skin. Check those that apply.

Oily Dry Combination Normal Sensitive Sun-damaged
 Freckled Mature Wrinkled Broken surface capillaries
 Hypo/Hyperpigmented Melasma Rosacea Eczema
 Psoriasis Acne Scarred Large Pores Small Pores

Do you have any particular skin problem or concerns? _____

How did you hear about Rejueva' Cosmetic Dermatology? _____

To the best of my knowledge, the information I have provided is true. I understand that this information is confidential and will not be disclosed without my written consent.

Patient or Legal guardian Signature: _____ Date: _____