Patient Intake Form

Welcome to Center for Plastic Surgery! We are committed to giving you the best possible service and treatments Please complete the following form as thoroughly as possible to help us achieve this goal. All information will be kept confidential. If at any time you have questions regarding your treatment or services, please let your Esthetician know.

Name (please print) _____ Date _____

Occupation _____ E-Mail Address _____

Whom may we thank for your referral? _____

What concerns do you have today about your skin? _____

In the past 30 days, please list all professional skin or dermatology services you have received (i.e. glycolic peel, micro-dermabrasion, laser, Botox, etc.) _____

Please list the skincare products you are currently using:

Cleanser		Serum	
Toner		Sun Screen	
Exfoliant		Eye Cream	
Moisturizer - Day		AHA/BHA	
Moisturizer - Night		Other	

Are you or have you been under a Dermatologist's care? Yes/No If yes please explain _____

Please circle if you are currently taking or using any of the following prescriptions:

Accutane	Differin	Retin A, Renova, Kinerase
Tazorac	Trentonin	Antibiotics

If you are taking antibiotics topically or orally, please list: _____

Other prescription medications/supplements: _____

Have you ever had a negative reaction to a cosmetic product or ingredient? _____

If yes, please name the products and describe your experience _____

Please take a moment to carefully read the following list of conditions and check any that have affected your health either recently or in the past.

_____	Wear contact lenses	_____	Pregnant	Due Date:	_____
_____	Herpes Virus (i.e. cold sores)	_____	Hormone Therapy		
_____	Skin Cancer	_____	High/Low Blood Pressure		
_____	Thyroid (over or under active)	_____	Heart Condition/Pacemaker		
_____	Diabetes	_____	Latex Allergy		
_____	Allergies	_____	Epilepsy/Seizures		
_____	Neuromuscular Condition	_____	Surgeries	What?/When?	_____

Do you have any other medical conditions such as infectious, contagious or communicable disease that your Esthetician should be aware of before you receive your service today (i.e. Hepatitis, HIV, MRSA, etc.)?
Please describe: _____

_____

_____

Have you ever had a sunburn? _____ If yes, how serious? _____

Have you had recent exposure to the sun or used a tanning bed? _____

Are you affected by any of the following conditions today?

_____	Headache	_____	Sinus Infection
_____	Stress	_____	Virus
_____	Cold	_____	Other

Are there other spa services that you would like to know more information about? _____

_____

_____

Waiver: *I understand and acknowledge there are risks involved with the treatment of facials, peels, micro-dermabrasion, waxing and tinting. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive the UW Neighborhood Medi-Spa's liability if such results or complications occur. I further understand my failure to follow post care instructions may also lead to undesired results, complications or effects and hereby waive UW Neighborhood Medi-Spa's liability if such results or complications occur. In consideration for UW Neighborhood Medi-Spa performing this procedure, I agree I will assume the risk and full responsibility for any and all injuries, losses or damages which might occur to me while I am undergoing this procedure or side effects I may experience after the procedure is performed.*

Signature	**Printed Name**	**Date**
Signature of Parent/Guardian if under 18	**Printed Name**	**Date**