Medical Spa Services
Intake Form

Last Name_____ First Name: _____ Date: _____

Address: _____Gender: M☐ F☐

City: _____State: _____Zip Code:_____

Cell Phone: _____Home Phone: _____Work: _____

Email Address: _____ Date of Birth:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

Please Check All Areas of Interest:

☐ Acne Treatment
☐ Botox
☐ Skin Correcting Peels
☐ Dermal Filler (Juvederm)
☐ Facials
☐ Reconstructive Surgery
☐ Skin Consultation
☐ Other: _____

☐ Skin Care Products
☐ Waxing
☐ Cosmetic Surgery
☐ Speak Directly with a Physician
☐ IPL/Laser Treatment
☐ Age Spot/Sun Damage Removal
☐ Microdermabrasion

Please Check Any Additional Skin Concerns:

☐ Fine Lines and Wrinkles
☐ Texture (Uneven Skin Tone, Pore Size, Smoothness, Scaring)
☐ Discoloration (Sun Spots, Age Spots, Melasma)
☐ Redness or Visible Capillaries
☐ Other: _____

Please Check if You Have the Following Skin Conditions:

☐ Skin Infection
☐ Herpes (Cold Sores)
☐ Keloids or Excessive Scarring
☐ Sun Sensitivity
☐ Other: _____

☐ Tattoos
☐ Skin Cancer
☐ Poor Healing or Diabetes
☐ Easy Bleeding or Bruising

Any current or known illness, disease, condition, or infection? ☐ Yes ☐ No

If you answered yes the above question, please explain here :

Please list all medication taken recently including over the counter medication, vitamins and herbs. Please be sure to include the dosage and frequency

Are you pregnant or nursing? ☐ Yes ☐ No ☐ Unsure

How did you hear about CARE Plastic Surgery? If you were referred by a specific person or physician, please lis their contact info as well.

Are you currently taking Accutane or using ☐ Retin A ☐ Renova ☐ Avita ☐ Differin *Please Check One*
Are you currently using Glycolic Acid Products? _____
Please specify what allergies you have, if any: _____
Do you wear contact lenses? _____
Do you have a history of fever blisters? _____
Do you have eczema, psoriasis, dermatitis? _____
Are you currently taking hormone replacement therapy? _____
Please check any and all of the following methods you have removed hair in the past 6 weeks:
☐ Tweezing ☐ Waxing ☐ Depilatories ☐ Electrolysis ☐ Shaving ☐ Other: _____

In the last 6 weeks what have been your tanning habits:
☐ Sun Exposure ☐ Tanning Bed ☐ Sunless Tanning Products ☐ None ☐ Other: _____

Previous Procedures:
☐ Laser/Light Treatments
☐ Microdermabrasion
☐ Dermal Fillers
☐ Chemical Peels
☐ Botox
☐ Other: _____

I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Patient Signature_____ Date_____