



DERMATOLOGY & AESTHETICS

Cosmetic Patient Intake Form

Name: _____ DOB: ____/____/____ Gender: Male ____ Female ____
Phone Number: _____ Email: _____

Okay, should I leave detailed messages on voicemail? (Please circle) Yes No

☐ I consent to receiving text messages on my cell phone for appointment reminders. These messages may contain office promotions.

☐ I decline cell phone text messages

Would you like to receive emails about office specials/promotions? (Please circle) Yes No

☐ I give my consent for Fox Dermatology and Aesthetics to communicate with me via email regarding my care

☐ I decline email communication

Address: _____ City: _____ State: ____ Zip: _____
Occupation: _____

Emergency Contact: _____ Phone Number: _____

Okay to discuss my health or billing information with:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

☐ Do not discuss my information with anyone

How did you hear about us? (Please check all that apply) ____ Instagram Account

____ Friend/Family: _____ ____ Yelp ____ Google ____ Facebook

____ Dermatologist Other: _____

Reason for visit:



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What is your current daily skin care regimen?

Health History

Previous Procedures: Which of the following have you had in the past? (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Neurotoxins (i.e. Botox, Dysport) | <input type="checkbox"/> Microneedling |
| <input type="checkbox"/> Injectable Fillers (i.e. Juvederm, Restylane) | <input type="checkbox"/> Sculptra |
| <input type="checkbox"/> RF Microneedling (i.e. Vivace, Morpheus8, Scarlet, Sylfirm) | <input type="checkbox"/> PDO Threads |
| <input type="checkbox"/> Moxi or Clear + Brilliant lasers | <input type="checkbox"/> Facials |
| <input type="checkbox"/> Laser Resurfacing (i.e. Halo, Fraxel, CO2) | <input type="checkbox"/> Dermaplane |
| <input type="checkbox"/> BBL, IPL, or Photofacial | <input type="checkbox"/> Hydrafacial or DiamondGlow |
| <input type="checkbox"/> Permanent Makeup or Microblading | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Facial Cosmetic Surgery: _____ | |

Current Medications: (Including topical medications like Retin-A, tretinoin, etc.)

Allergies: (Including latex, medications, food, etc.)

Are you pregnant? Y N Are you nursing? Y N Are you planning on becoming pregnant? Y N
Are you currently taking ACCUTANE, or have you taken Accutane in the last 6 months? Y N

Do you use tanning beds? Y N Do you wear sunscreen DAILY? Y N Do you smoke? Y N



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Any Dental work/cleaning in the last 2 weeks or an upcoming appointment in the next 2 weeks? Y N

Are there any flights within the next 72 hours? Y N

Past Personal Medical History: (Please check all that apply)

☐ Autoimmune Disease ☐ IUD (current) ☐ Lyme Disease ☐ Hyperthyroid ☐ Diabetes ☐ Lupus
☐ Hypothyroid ☐ Fibromyalgia ☐ Metal Implants or Plates ☐ Blood Clots, Bleeding Disorders ☐ Heart
Disease ☐ PCOS ☐ Cancer ☐ Hepatitis B or C ☐ Seizures ☐ Cold Sores (ever, even years ago)
☐ Hormone Therapy ☐ Stroke ☐ Connective Tissue Disorder ☐ High Blood Pressure ☐ Hysterectomy
☐ HIV/AIDS ☐ Cochlear implant, Pacemaker, Defibrillator, or any other electrical devices

Other:

Past Personal Skin History: (Please check all that apply)

☐ Undiagnosed Skin Lesions ☐ Lupus ☐ Keloid Scars ☐ Psoriasis ☐ Actinic Keratosis (pre-cancer)
☐ Melasma/"pregnancy mask" ☐ Shingles ☐ Eczema ☐ Pigment Disorder (i.e., Vitiligo) ☐ Rosacea
☐ Skin Cancer – circle all that apply: Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma ☐
History of cold sores/Fever Blisters/Herpes Simplex

Previous Surgeries:
