RejuvedermMD
AESTHETIC CENTER

What are your cosmetic concerns? (check all that apply)

- ☐ Fine Lines and Wrinkles
- ☐ Significant Lines Around Nose & Mouth
- ☐ Hyperpigmentation (Dark Spots) & Freckles
- ☐ Facial Hair
- ☐ Acne
- ☐ Dry Skin
- ☐ Dark Under Eye Circles
- ☐ Sagging Skin
- ☐ Unwanted Facial or Body Hair
- ☐ Tired Looking Skin/Rough Texture
- ☐ Stretch Marks
- ☐ Fat Reduction (Body/Chin)

When looking at my face in the mirror, I believe I look younger, the same as or older than my true age?

Younger Than		True Age		Older Than
1	2	3	4	5

When looking at my face in the mirror, I am conerned, somewhat concerned or very concerned about the appearance of my skin?

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

If you could improve anything about your appearance, what would it be? _____

_____

Are you interested in learning more about the following? (check all that apply)

- ☐ Botox/Dysport
- ☐ Cosmetic Filler
- ☐ Laser Hair Removal
- ☐ Pharmaceutical grade Skin Care/Retin A
- ☐ Microdermabrasion
- ☐ Skin Rejuvenation
- ☐ Leg Vein Removal
- ☐ Age/Liver Spots
- ☐ Sun Protection
- ☐ Chemical Peels
- ☐ Facial Vein Removal
- ☐ Birthmarks

Please list your current skincare regimen: _____

Date of last sun exposure, last time you were in a tanning bed or used a self tanner: _____

Going back three generations what is your heritage? (Indian, Native American, Asian, Latin, African, European) _____

Fitzpatrick Skin Test: (Please circle one)

Type I: pale white skin; always burns, tans, red or blonde hair, light eyes.

Type II: fair skin, blue eyes; burns easily, rarely tans

Type III: darker white skin; tans after initial burn

Type IV: light brown/olive skin; burns minimally, tans easily

Type V: brown skin; rarely burns, tans/darkens easily

Type VI: dark brown or black skin; never burns, always tans dark

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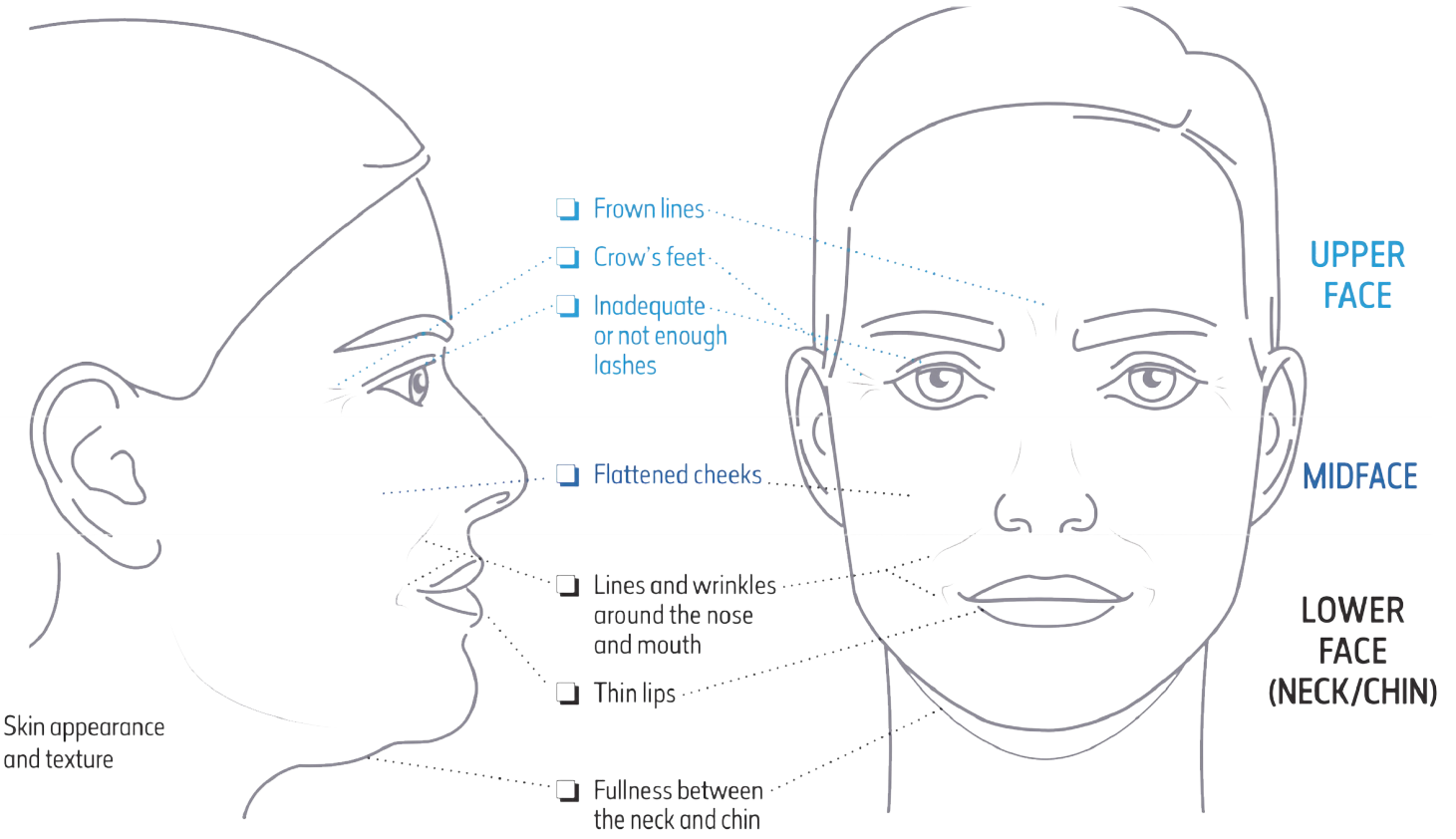
What previous cosmetic services/products have you had done/used? (check all that apply)

- ☐ Chemical Peel
- ☐ Microdermabrasion
- ☐ Botox/Dysport/Xeomin
- ☐ Laser Treatments; Please Specify: _____
- ☐ Cosmetic Surgery; Please Specify: _____
- ☐ Prescription Topical Creams
- ☐ Retinol Products
- ☐ Cosmetic Filler

Are you currently being treated at another medical spa or dermatology office? (please circle) Y or N

Please select which areas concern you on the diagram below:



Patient Signature: _____ Date: _____