RejuvedermMD
AESTHETIC CENTER

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Employer: _____ Occupation: _____

Emer. Contact: _____ Phone: _____ Relation: _____

How did you hear about us? _____

May we leave a detailed message on your phone for you? (please circle) Y or N

May we email you with specials we are offering? (please circle) Y or N

Are you currently under a physician's or specialist's care? Y or N Explain: _____

Do you, or have you had, any of the following conditions? (please circle)

Herpes Simplex:	Y	N	Corneal Abrasions:	Y	N
Smoke:	Y	N	Tumors/Growths:	Y	N
Asthma:	Y	N	Hyperpigmentation:	Y	N
Skin Cancer:	Y	N	Circulatory Problems:	Y	N
Epilepsy/Fainting:	Y	N			

Do you wear contacts? Y or N
Have you undergone Chemotherapy or Radiation? Y or N
Have you undergone a Blepharoplasty (eye lift surgery)? Y or N
Have you had laser skin resurfacing in the past year? Y or N
Are you currently using Retin-A? Y or N
Have you taken Accutane in the past nine months? Y or N
Are you pregnant or nursing? Y or N
Have you ever tested positive for HIV? Y or N
Do you have an immune disorder that would impair your healing process? Y or N
Are you prone to cold sore, genital warts or herpes breakouts? Y or N
Are you currently taking birth control? Y or N
When a scar appears on your skin, is it significantly dark in color? Y or N

List of Current Medications: _____

List of Any Drug, Makeup, Food or Skin Allergies: _____

Major Allergies (please circle):

Milk:	Y	N	Retinoic Acid:	Y	N
Aspirin:	Y	N	Fruit/Vegetable:	Y	N

Patient Signature: _____ Date: _____