Rockledge MedSpa

Patient's Name: _____

6410 Rockledge Drive, Suite 205, Bethesda, MD 20817 · 301-968-1210

Patient Intake Form

DOB: _____

Medical & Aesthetic History

Are you under the care of a Dermatologist? Yes □ No □
Dermatologists Name: _____ Reason for Treatment: _____

Do you take any over the counter medications (including Dietary Supplements, Vitamins, Herbal Supplements, Aspirin, etc.) regularly? Yes □ No □
If Yes, Please Describe: _____
_____

List any medications you take regularly: _____
_____

Do you smoke? Yes □ No □
Do you wear contact lenses? Yes □ No □
Do you have any metal implants or wear a pacemaker? Yes □ No □
What is your stress level? High □ Medium □ Low □
Do you have any problems with Anesthesia? Yes □ No □
Do you have any problems with Bleeding? Yes □ No □

For Women

Are you Pregnant: Yes □ No □ Due Date: _____
Are you trying to become Pregnant? _____ Yes □ No □ Are you Lactating? Yes □ No □
Are you on Oral Contraceptives? Yes □ No □
Any recent changes to your contraceptive treatment? Yes □ No □
If yes, what and when? _____
Any menopause problems? Yes □ No □
If yes, please specify: _____

Do you have any of the following:

□ Any Active Infection
□ Diabetes
□ Fever Blisters/Cold Sores
(Last Episode:_____)
□ Hepatitis
□ Immune Disorders
□ Seizure Disorder
□ Eczema or Psoriasis
□ Thyroid Condition

Skin Conditions or Concerns:

- ☐ Acne-Face
- ☐ Aging
- ☐ Back/Chest Acne
- ☐ Blackheads
- ☐ Burn
- ☐ Dark Under-Eye Circles
- ☐ Discoloration
- ☐ Dry Skin
- ☐ Elasticity Loss
- ☐ Enlarged Pores
- ☐ Facial Hair
- ☐ Facial Veins/Capillaries
- ☐ Freckles/Brown Spots
- ☐ Jowls (sagging skin)
- ☐ Lines/Wrinkles
- ☐ Oiliness
- ☐ Pre/Post-Operative Care
- ☐ Razor Bumps
- ☐ Redness
- ☐ Rosacea
- ☐ Scarring
- ☐ Sunburns
- ☐ Sun Damage
- ☐ Tone/Texture
- ☐ Uneven Skin
- ☐ Unwanted Hair (Specify: _____)
- ☐ Other: _____

Have you ever had any of the following treatments?

- ☐ Botox or Dysport — When was your last treatment? _____
- ☐ Restylane, Perlane, Juvederm, or Other fillers — When was your last treatment? _____
- ☐ IPL (Intense Pulse Light) — When was your last treatment? _____
- ☐ Microdermabrasion — When was your last treatment? _____
- ☐ Peel (Lactic, Glycolic, Salicyclic, Chemical) — When was your last treatment? _____
- ☐ Facial — When was your last treatment? _____
- ☐ Thermage — When was your last treatment? _____
- ☐ Laser Hair Removal — When was your last treatment? _____
- ☐ Cosmetic Surgery — When was your last treatment? _____
- ☐ Cosmetic Injections — When was your last treatment? _____
- ☐ Laser Treatments — When was your last treatment? _____

Do you Take/Use?

- ☐ Accutane- If, you have ever taken, ending when? _____
- ☐ Cortisone Cream
- ☐ Hormone Replacement Therapy
- ☐ Oral Antibiotics
- ☐ Tretinoin, Retin A, Renova, Retinol, or any Retinoid

How long have you been using this medication? _____

Sun Exposure History

Do you Sunburn/Tan Easily?
__ Always Burn, Never Tan
__ Seldom Burn, Tan Easily
__ Never Burn, Tan Easily
__ Usually Burn, Tan with Difficulty

Approximate Sun Exposure:
__ Minimal
__ Occasional
__ Recreational
__ Occupational

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes □ No □

Have you been exposed to the sun or used a tanning bed in the last 48 hours? Yes □ No □
How often do you use a Tanning Bed? _____

Do you use an SPF Daily? Yes □ No □
If Yes, which brand? _____ What level of SPF? _____

What is your Natural Coloring?
Eyes: _____ Hair: _____ Skin: _____

Have you ever had Skin Cancer? Yes □ No □
If Yes, when and what kind: _____

Do you use Prescription Medication for your skin? Yes □ No □
If Yes, please list: _____

What Skincare Products are you currently using?

_____ _____
_____ _____
_____ _____

Is there anything else that we should know? _____

I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE THE PRACTICE OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE: _____ DATE: _____

PRINTED NAME:_____