UPTOWN
MEDICAL AESTHETICS

New Client Intake

Welcome to Uptown Medical Aesthetics!

Please take a few moments to complete your contact information and Medical History for us to carefully evaluate and address your needs.

PLEASE WRITE LEGIBLY

Name: _____Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: Male/Female

Cell Phone: _____ May we text your appointment confirmations? Y/N

If yes, who is your cellular provider? _____

Email Address: _____ Receive Monthly Promotional Emails? Y/N

May we email your appointment confirmations? Y/N

Emergency Contact: _____ Phone: _____

Source of Referral: (circle one) Printed Ad Facebook/Instagram YouTube Internet Search

Friend/Relative (Name: _____)

Do you regularly see a Physician for any Medical Concerns or diagnoses? Yes/No

Are you currently under the care of a Dermatologist? Yes/No

Have you ever had any of the following conditions or treatments?

Acne
Any Active Infection
Arthritis
Autoimmune Condition
Blood Clotting Disorder
Facial/Oral Surgery
Moles
Psoriasis
Sinus Infections
Cancer
Epilepsy or Seizures
Cold Sores
Dermatitis
Diabetes
Eczema
Endocrine Problems
Genital Herpes
Heart Condition
Hepatitis
High Blood Pressure
HIV/AIDS
Hormone Imbalance
Keloid Scarring
Lupus
Pace Maker
Permanent Makeup
Seizure Disorder
Skin Disease/Lesions
Tattoos
Thyroid Imbalance
Varicose Veins

Other: _____

Do you have a history of Erythema Abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes/No

Do you have any other medical problems we should be aware of? Yes/No If yes, please list:

_____

Do you have any allergies to medications, topical anesthesia, or latex? Y/N Please list:_____

Do you smoke? Y/N Do you drink alcohol? Y/N

Are you currently taking any mood altering or anti-depression medications? Yes/No

Are you currently applying any topical medications to your skin? Yes/No If yes, please list: _____

Do you take vitamins, prescriptions, or herbal supplements, including Vitamin E or Fish Oil? Yes/No If yes, please list:

_____

*****If you are interested in, or are receiving laser*: Have you had any recent change in the color of your skin from natural sun exposure, tanning beds/lamps or from the application of self-tanning products? Yes/No**

Does your daily skincare protocol include any/all of the following? (circle all that apply)

Growth Factors Retinol Anti-Oxidants Skin Lighteners Anti-Aging Products Sunscreen

What is the reason for your visit today? _____

What other concerns do you have that we can assist with? (check all that apply)

Fine Lines	**Dark Spots**	**Unwanted Hair**
Wrinkles	**Melasma**	**Unwanted Fat**
Pore Size	**Acne**	**Vaginal Dryness or Laxity**
Aging Skin	**Acne Scarring**	**Stress Urinary Incontinence**
Look Angry, Tired or Old	**Thin Lips**	

For women:

- **Are you pregnant or trying to become pregnant? Yes/No**
- **Are you nursing? Yes/No**
- **Are you using Birth Control? Yes/No**

By signing below, I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform Uptown Medical Aesthetics of my current medical or health conditions and to update this history. A current medical history is essential for the technician to execute appropriate treatment procedures.

Signed: _____ Date:_____