Pensacola Physical Medicine, Inc.
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Aesthetic Intake Form

Date: _____

NAME: _____ AGE: _____ Date of Birth: _____

ADDRESS: _____ CITY: _____ ZIP: _____

MOBILE PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

ALTERNATE PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

E-MAIL: _____ ☐ OK TO CONTACT

OCCUPATION: _____ How did you hear about us? _____

In order of importance, beginning with 1, please rank what you would like to see improved in your skin:

_____ Reduction of wrinkles and fine lines _____ Reduction of brown spots/sun damage

_____ Reduction of oil/acne _____ Reduction of Hair _____ Reduction of redness _____ Tattoo Removal
_____ Other: _____

Medical History	Yes	No	Please check all medical conditions past or present	Yes	No
Do you use sunscreen daily with SPF 30 or higher?			Eczema		
Have you ever had a skin cancer? Type:			Thyroid imbalance		
Have you ever had a photosensitive disorder? (e.g. Lupus)			Diabetes		
Do you have a personal history of seizures?			Heart condition		
Permanent make-up or tattoos? Where:			High blood pressure		
Have you used Accutane in the last 6 months?			Pacemaker		
Are you currently taking any antibiotics? Which:			Disease of nerves or muscles (e.g. ALS, Myasthenia gravis, Lambert-Eaton or other)		
Are you using Retin-A or Glycolic products?			Cancer		
Poor Healing			HIV/AIDS		
Do you have an allergy or sensitivity to lidocaine, latex, sulfa medications, hydroquinone, aloe, bee stings? (If yes, circle)			Autoimmune disease (e.g. rheumatoid arthritis, Scleroderma)		
Life threatening allergy to anything?			Hepatitis		
Do you currently smoke?			Shingles		
Do you have scars on the face?			Migraine headaches		
Explanation of items marked "Yes":			Other illness, health problems or medical conditions not listed:		
List your Common Outdoor Activities:					

I certify that the information I have given is complete and accurate. _____Initials _____Staff initials