Horizons OB-GYN & Aesthetics

New Patient Intake Form – Aesthetics

Please complete this brief history to assist me in providing you with the best care possible.
This form will be added to your medical record.

Name:_____Date of Birth:_____Today's Date:_____

Address: _____City_____Zipcode:_____

Phone Number: _____E-mail address: _____

Pharmacy name: _____ Address/phone #::_____

How did you hear about us? _____ Friends? Who?_____? ___Referral? Who?_____
____google _____insurance? _____social media?

Reason for Visit:_____

Any recent facial treatments, if so, what was it and when:

Any problems with botox,dysport or fillers:

MEDICAL HISTORY (either now or in the past/detail below with year of diagnosis and treatment given)

☐ Asthma	☐ Inflammatory bowel disease	Psychiatric diagnosis
☐ Cancer	☐ Lupus	☐ Anxiety
☐ Cardiac disease	☐ Osteoporosis/Osteopenia	☐ Depression
☐ Diabetes	☐ Stroke	☐ Bipolar disorder
☐ Hypertension/high blood pressure	☐ Thrombotic disorder (blood clots)	☐ Other: _____
☐ Hyperlipidemia/cholesterol	☐ Thyroid disease (low/high)	_____
☐ Irritable bowel syndrome	☐ Reflux (GERD)	_____

CURRENT MEDICATIONS (include vitamins, herbs, and other supplements)

NAME OF MEDICATION	DOSAGE	HOW OFTEN

ALLERGIES

Are you allergic to any medications? □ No □ Yes (Please specify the medication and reaction):

_____

SURGICAL HISTORY

NAME OF PROCEDURE	DATE OF PROCEDURE	REASON FOR PROCEDURE

SOCIAL HISTORY

Do you exercise? If so what do you do_____

Occupation_____Marital Status_____

Do you smoke?_____How many packs a day?_____If you quit, when was this?_____

Do you drink alcohol?_____How many drinks per week?_____Any other drugs?_____Which other drugs?_____

WHAT ARE YOUR TOP 3 SKINCARE CONCERNS:

1._____
2._____
3._____

PREVIOUS TREATMENTS:

Facials: ▢ No ▢ Yes Last Treatment_____Any complications?_____

Cosmetic Procedures:▢ No ▢ Yes Last Treatment_____Any complications?_____

Chemical Peels: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Injectables: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Hair Removal: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Tanning: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Laser Therapy: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Light Therapy: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Microcurrent: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Other ▢ No ▢ Yes Last Treatment_____Any complications? _____

SKIN CONDITIONS: (*please check all items below that pertain to you)*

▢Skin Infection	▢Herpes	▢Keloids/Excessive Scarring
▢Skin cancer_____	▢Poor Healing	▢Tattoos/Permanent Makeup
▢Eczema/Psoriasis	▢Lymph Nodes Removed	▢Mold Exposure
▢Sun Sensitivity	▢Easy Bruising	▢Auto Immune Condition_____

SKINCARE: What type of skin do you feel you have? ▢Dry ▢Oily ▢Normal ▢Combination

What is your skin routine? (*Indicate any cleansers, toners, serums, moisturizers, masques, etc.)*

1._____ 4._____

2._____ 5._____

PHYSICIANS

Medical/Primary Care Physician:_____Phone #_____

Other Physician: _____Phone #_____

EMERGENCY CONTACT

Name_____Phone #_____Relationship_____