Medical Aesthetic Patient Registration Form

_____ _____ _____ ___/____/___ M / F _____

First Name *Last Name* *MI* *DOB* *Age*

_____ _____ _____ _____ _____

Street Address *Apt/Unit* *Town/City* *State* *Zip*

_____ _____

Email *Cell Phone*

*How did you hear about us? Circle One: FB / IG / Website / **RealSelf** / Friend / Family member Email list*

Aesthetic Concerns or Interest:

_____

_____

Prior Aesthetic or Laser Treatments: Y / N If yes, explain:

_____

_____

Chronic Medical/Surgical History: _____

_____

Circle if you have: *Diabetes Heart Disease Circulation/Clotting Problems Keloids*

Skin Infection/Wound Recent Surgery Tumors/Cancers Heart Rhythm Issues

PREGNANT *Herpes Shingles Scars Tattoo Implants Piercing* ***Cold Sores***

Acne Muscle Disease Pacemaker/Defibrillator Other Rash/Skin Problems

2826 Old Lee Highway, Suite 250, Fairfax, VA 22031 Ph: (703)854-1298 Email: Style@carelife.md Web: carelife.style

Current Medication / Supplements: _____

_____

ALLERGIES: _____

_____

Other Aesthetic or Skin Concerns: _____

_____

_____

_____ _____

Patient Signature *Date*

_____ _____ _____

Reviewed by Clinical Provider *Signature* *Date*

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