HEALTHY
COMPLEXIONS SPA
by Western New York Dermatology

# INTAKE FORM

Date of Birth ________________

First Name ________________________ Last Name ________________________

Street Address ________________ City ____________ State ________ Zip ______

Phone ________________________ Email ________________________________

Whom can we thank for referring you? ________________________________

## Skin History

When was your last skin check? ________________________________

**Have you previously had any of the following?**

- ◯ Laser procedures
- ◯ Chemical peels
- ◯ Thread lift
- ◯ Facial surgery
- ◯ Hydrafacial
- ◯ Skin cancer
- ◯ Filler
- ◯ Botox/Dysport/Xeomin
- ◯ Precancerous lesions

**What skincare products do you use?**

◯ Soap ◯ Cleanser ◯ Toner ◯ Moisturizer ◯ Serum ◯ Scrub ◯ Mask ◯ Sunscreen

**What is your skintype?** ◯ Dry ◯ Normal ◯ Oily ◯ Combination ◯ Sensitive

**Are you or have you been on any of the following?**

| | Yes | No | If yes, When? |
|---|---|---|---|
| Isotretinoin (Accutane) | ☐ | ☐ | ______ |
| Oral antibiotics | ☐ | ☐ | ______ |
| Topical antibiotics | ☐ | ☐ | ______ |
| Topical sterioids | ☐ | ☐ | ______ |
| Tazorac | ☐ | ☐ | ______ |
| Tretinoin/Retinol, Retin-A, Differin, etc | ☐ | ☐ | ______ |
| Finacea | ☐ | ☐ | ______ |
| Hydroquinone | ☐ | ☐ | ______ |
| Benzoyl peroxide | ☐ | ☐ | ______ |
| Glycolic/salicylic asids | ☐ | ☐ | ______ |
| Blood thinners | ☐ | ☐ | ______ |
| Other current prescriptions or topicals | ☐ | ☐ | ______ |

We treat your skin.
You treat yourself.

297 Spindrift Drive
Williamsville, NY 14221
716.300.1444

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**Have you had or do you have any of the following conditions:**

- ☐ Acne
- ☐ Acne scars/scarring
- ☐ Itchy/flakey/scaly scalp
- ☐ Cardiac problems
- ☐ Fever blisters
- ☐ Immune disorder
- ☐ Kidney/urinary tract problems
- ☐ Rosacea
- ☐ Unwanted hair
- ☐ Sun damaged skin
- ☐ Metal pins/plates
- ☐ Herpes
- ☐ Diabetes
- ☐ Eczema
- ☐ Hair loss
- ☐ Unwanted fat
- ☐ Pacemaker
- ☐ HIV+
- ☐ Keloids
- ☐ Psoriasis
- ☐ Cellulite
- ☐ Skin laxity
- ☐ Epilepsy
- ☐ Hepatitis

**List any topical/oral allergies** ______________________________

______________________________

**List all concerns that you would like to improve and treatments that you may be interested in**

______________________________

______________________________

**I agree to receive appointment confirmations and promotions via text and email**

◯ **Text** ◯ **Email** ◯ **Both** ◯ **Neither**

## For women only

| | Yes | No |
|---|---|---|
| Are you pregnant or breast feeding? | ◯ | ◯ |
| Are you trying to become pregnant? | ◯ | ◯ |
| If you have been pregnant, have you had hyperpigmentation or “pregnancy mask”? | ◯ | ◯ |

**Signature** ______________________________ **Date** ______________________________

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I agree that WNY Dermatology/Heatlhy Complexions Spa may use photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

**I have read and understand the above:**

**Signature** ______________________________

**Spa representative** ______________________________

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