

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? *(check all that apply)*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> BOTOX/Dysport/Xeomin    | <input type="checkbox"/> Microneedling     | <input type="checkbox"/> Facial Surgery           |
| <input type="checkbox"/> Dermal (facial) Fillers | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Facial                   |
| <input type="checkbox"/> Laser Procedures        | <input type="checkbox"/> Chemical Peel     | <input type="checkbox"/> Other cosmetic procedure |

What skincare products do you use?

- |                                   |                                      |                                    |
|-----------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Soap     | <input type="checkbox"/> Moisturizer | <input type="checkbox"/> Mask      |
| <input type="checkbox"/> Cleanser | <input type="checkbox"/> Serum       | <input type="checkbox"/> Sunscreen |
| <input type="checkbox"/> Toner    | <input type="checkbox"/> Scrub       |                                    |

What is your skin type?  Dry  Normal  Oily  Combination  Sensitive

In the sun, what does your skin do?  Always burns, never tans  Mildly burns, slowly tans  
 Rarely burns, tans with ease  Never burns, tans easily

Are you currently or have you recently been using any of the following prescriptions?

- |  | If yes, when? |  | If yes, when? |
|--|---------------|--|---------------|
| <input type="checkbox"/> Isotretinoin (Accutane)                       | _____         | <input type="checkbox"/> Finacea                                       | _____         |
| <input type="checkbox"/> Oral antibiotics                              | _____         | <input type="checkbox"/> Hydroquinone                                  | _____         |
| <input type="checkbox"/> Topical antibiotics                           | _____         | <input type="checkbox"/> Benzoyl peroxide                              | _____         |
| <input type="checkbox"/> Topical steroids                              | _____         | <input type="checkbox"/> Glycolic/salicylic acids                      | _____         |
| <input type="checkbox"/> Tazorac                                       | _____         | <input type="checkbox"/> Blood thinners                                | _____         |
| <input type="checkbox"/> Tretinoin/Retinol,<br>Retin-A, Differin, etc. | _____         | <input type="checkbox"/> Other current<br>prescriptions or<br>topicals | _____         |

**Medical History:** (Check the appropriate box for any condition for which you have ever been treated)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acne                | <input type="checkbox"/> Skin cancer                 | <input type="checkbox"/> Polycystic Ovarian Syndrome  |
| <input type="checkbox"/> Rosacea             | <input type="checkbox"/> Precancerous Lesions        | <input type="checkbox"/> Diabetes/Diabetic Neuropathy |
| <input type="checkbox"/> Melasma             | <input type="checkbox"/> Melanoma                    | <input type="checkbox"/> Blood Disorder               |
| <input type="checkbox"/> Skin Pigmentation   | <input type="checkbox"/> Cancer/Radiation Therapy    | <input type="checkbox"/> Autoimmune Disorder          |
| <input type="checkbox"/> Keloid Scars        | <input type="checkbox"/> Shingles                    | <input type="checkbox"/> Pacemaker                    |
| <input type="checkbox"/> Acne/Surgical Scars | <input type="checkbox"/> Herpes (or cold sore)       | <input type="checkbox"/> Epilepsy                     |
| <input type="checkbox"/> Eczema              | <input type="checkbox"/> HIV+                        | <input type="checkbox"/> Metal Pins/Plates            |
| <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Cardiac Problems             |
| <input type="checkbox"/> Vitiligo            | <input type="checkbox"/> Hormonal Imbalances         | <input type="checkbox"/> Kidney Disease               |
| <input type="checkbox"/> Hair Loss/Thinning  | <input type="checkbox"/> Steroid or Hormonal Therapy |   |

List any topical/oral allergies \_\_\_\_\_

What questions or concerns bring you in today?

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

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**For women only**

Are you pregnant or breastfeeding? Yes  No  Are you trying to become pregnant? Yes  No

If you have been pregnant, did you have hyperpigmentation or a "pregnancy mask"? Yes  No

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Spa Representative Signature*

\_\_\_\_\_  
*Date*

## Authorization for in-office use of photo and video

I, \_\_\_\_\_, hereby grant permission to WNY Dermatology/Healthy Complexions Spa, its representatives and employees, to take photographs and or video of me and my property **for in-office use, for medical charting and for progress tracking.**

---

*Signature*

*Date*

---

*Spa Representative Signature*

*Date*

## Authorization for marketing use of photo, video and testimonial

I, \_\_\_\_\_, hereby grant permission to WNY Dermatology/Healthy Complexions Spa, its representatives and employees, to take and use my photograph and or video, and any testimonial I give regarding the treatment(s) I receive **to market or advertise its products and services**, including use on the Healthy Complexions Spa website and/or social media, or in print. I acknowledge that I will not receive payment in any way in return for providing my consent, for completing this form, or for the marketing use of my photo and/or testimonial. I also acknowledge that WNY Dermatology/Health Complexions Spa may choose not to use my photograph, video and/or testimonial at this time but may do so at its own discretion at a later date.

---

*Signature*

*Date*

---

*Spa Representative Signature*

*Date*