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? *(check all that apply)*

- ☐ BOTOX/Dysport/Xeomin
- ☐ Dermal (facial) Fillers
- ☐ Laser Procedures
- ☐ Microneedling
- ☐ Microdermabrasion
- ☐ Chemical Peel
- ☐ Facial Surgery
- ☐ Facial
- ☐ Other cosmetic procedure

What skincare products do you use?

- ☐ Soap
- ☐ Cleanser
- ☐ Toner
- ☐ Moisturizer
- ☐ Serum
- ☐ Scrub
- ☐ Mask
- ☐ Sunscreen

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?
☐ Isotretinoin (Accutane)	_____	☐ Finacea	_____
☐ Oral antibiotics	_____	☐ Hydroquinone	_____
☐ Topical antibiotics	_____	☐ Benzoyl peroxide	_____
☐ Topical steroids	_____	☐ Glycolic/salicylic acids	_____
☐ Tazorac	_____	☐ Blood thinners	_____
☐ Tretinoin/Retinol, Retin-A, Differin, etc.	_____	☐ Other current prescriptions or topicals	_____

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

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

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*

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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*