Broome Nurse Practitioners
SKINCARE

AESTHETIC INTAKE FORM

Name: _____

Birthdate: _____

Address: _____ Zip Code_____

Email Address: _____

Would you like to receive educational and promotional emails from us? □Yes □No

Mobile Phone: _____ OK to contact OK to leave message or text

Home Phone: _____ OK to contact OK to leave message

Work Phone: _____ OK to contact OK to leave message

How did you hear about us? _____

Primary Care Provider: _____

Allergies to Medications: _____

_____

Allergies (seasonal, animal, insect, foods): _____

_____

Medications: _____

_____

_____

What are your top concerns when it comes to your skin? _____

_____

Please answer yes or no to the following. Do you have:

Any side effects or allergies to botulinum toxin products? YES NO

Any allergy to bee stings? YES NO

Any allergy to cow's milk? YES NO

Any active skin infection? YES NO

Problems with blood clotting or bleeding? YES NO

Do you form thick scars (Keloid)? YES NO

History of oral herpes/cold sores? YES NO

A disease that affects your muscles? (ALS or Lou Gehrig's disease, myasthenia gravis, Eaton-Lambert syndrome or other motor neuron disease)? YES NO

History of Autoimmune disease? YES NO

Are you taking an immunosuppressant? YES NO

Have you had Accutane in the last 12 months? YES NO

History of surgery on your face or plan to get surgery on your face? If so, what? YES NO

Treatment for skin cancer on your face? What kind and what location? YES NO

Are you pregnant or planning to get pregnant in the next 3 months? YES NO

Are you breastfeeding? YES NO

I understand the information on this form is essential to determine my medical and cosmetic needs and the appropriate provision of treatment. I understand that if there are any changes in my medical history / health, I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Signature: _____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos to be a part of the medical record to be used as documentation of response to treatment. **Initial ____**

I authorize that photographs may be used for marketing purposes both in publications and presentations for and on **Broome Family Nurse Practitioners** social media accounts and website. I understand my identity will be concealed if I wish/specify. **Initial ____** **If you wish your identity to be concealed initial here ____**

If no please initial here_____

I hold **Broome Family Nurse Practitioners PC** harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial ____**

Dermatology Medical History Form

Name: _____ Age: _____ Date of birth: _____

Height: _____ Weight: _____

Please circle any medical conditions that apply:

Pacemaker	Kidney problems
Defibrillator	Arthritis
Asthma	Artificial Joints
Hay Fever	Appendix Removed
Seasonal Allergies	HIV or AIDS
Eczema	Hepatitis A B C (please circle)
Psoriasis	Liver Cirrhosis
Diabetes controlled by (circle)	Liver Problems Type_____
Diet Medication Insulin	Bleeding disorder
High Cholesterol	Anxiety
High Blood Pressure	Depression
Stroke	Gallbladder Removed
Heart Attack	Pregnant
Congestive Heart failure	Breast Feeding
Heart Murmur	Planning Pregnancy
Heart Valve Problem	Hysterectomy: Total or Partial
Acne	Tubal Ligation
Thyroid Disorder	Prone to Yeast Infections with Antibiotics

Have you ever been told to take antibiotics before dental procedures due to a heart murmur, heart valve or artificial joint?

Yes No (please circle)

Melanoma: If yes, where and when? _____

Basal Cell: If yes, where and when? _____

Squamous Cell: If yes, where and when? _____

Blistering sunburn: if yes, number of times and where? _____

Skin type: If first exposure to the sun, without sunscreen would you (please circle)

Always Burn Sometimes Burn Never Burn Always tan

Surgeries: _____ **Date:** _____ **Hospitalized:** Y/N

_____ _____ Y/N

_____ _____ Y/N

Please list any other surgeries or medical problems: _____

SOCIAL HISTORY

Do you smoke or use tobacco? YES NO (circle one)

If yes, what type? _____ How many per day? _____ Are you a former smoker? YES NO (circle one)

Do you drink alcohol? YES NO (circle one) How many per week?_____

Family History: Circle any condition affecting a blood relative. Specify which family member.

Melanoma_____ Breast Cancer_____

Psoriasis_____ Acne_____

Allergies_____ Asthma_____

Basal cell or Squamous Cell Skin Cancer_____

Scheduling and Cancellation Policy

Your appointments are very important to us, it is reserved especially for you. We understand that sometimes schedule adjustments are necessary; therefore, we respectfully request 48 hours' notice for reschedules or cancellations.

Please understand that when you forget about your appointment or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and clients on our waiting list miss the opportunity to receive services.

For all new and regular filler clients, we please ask to make a scheduling deposit of $100. This can be paid when making your appointment. The $100 will be used towards your treatment on the day. Please also note that the scheduling fee is nonrefundable. If you give 48 hours' notice, we will hold your deposit on file for no longer than 12 months. This deposit can then be used towards any service we provide. We appreciate your understanding and support.

If you need to reschedule your appointment, please notify our team 48 hours in advance. One reschedule will not forfeit your booking deposit, but a second reschedule will forfeit the deposit. Please also note that the scheduling fee is non refundable if you fail to attend your appointment as a no-show.

_____

Signature and Date