Date ___________

Welcome to BU Wellness & Med Spa
Client Intake Form

Patient Information

Last Name: ____________________________ First Name: ____________________________
Address: ____
Date of Birth: __________________ Gender: M F
Phone Number: (H) ______________________ (Cell) _______________________________
Email Address: ____

How did you hear about us? Facebook Instagram Internet Doctor Friend/Family
Newspaper Walk-in Other ____________________
Reason for Visit: ____
What changes you would most likely to see in your skin? ______________________________

Would you be interested in information regarding cosmetic procedures:
(circle all that apply) Botox/Dysport, Fillers, Chemical Peels, Skin Resurfacing
Dermaplane, Hydrafacial, Wrinkle Reduction, Laser Hair Removal, Age/Sun Spots
Acne, Rosacea, Facial Veins, PRP Therapy, Mole/Wart Removal Other:__________

About You

Ethinc Background: White Asian Mediterranean Hispanic African American
Middle Eastern Native American Other_____________________________________
Natural Eye Color : ____________________ Natural Hair Color ____________________
Skin Type *(circle all that apply)* Normal Sensitive Dry Oily Combination Acne
Rosacea Eczema Freckled Hyperpigmentation Sun-damaged Melasma Saggy
Wrinkles Broken capillaries Other ____
Contact Lenses ____ Use Sunscreen ____ Tattoos or permanent make up ______

Occupation: ________________________________ Employer: ______________________

Women only: Are you pregnant or lactating? ____ Yes ____ No

We appreciate your family/friends referrals & Google/Yelp reviews!

Social History

Vigorous exercise or sports? Yes ____ No ____

Do you smoke, vape or use tobacco? Yes ____ No ____

Do you drink alcohol? ____ Yes ____No If yes, how many drinks per week? ______

Medical History

ALLERGIES?? (medications, contrast dye, food or latex) Yes ____ No ____

If Yes, please describe: ____

Have you had in the past or currently have: ___Diabetes ___Hypertension

___ Stroke ___Heart Disease ___Irregular Heart beat ___Thyroid Disease

___Asthma ___ Lupus ___Heart Attack ___ Seizure disorder ___Fainting

___Polycystic Ovary Disease ____Cancer ___Shingles ___Keloid ____Pacemaker

___Implants ___Herniated Disc OTHER _____________________________________

List any surgeries you have undergone: _______________________________________

Medications you are currently taking: _______________________________________

Are you currently taking any of the following medications, topical or otherwise?

Tretinoin/Retin-A, Renova, Differin, Tazorac, Avage, EpiDuo, Ziana Yes _____ No _____

Have you taken **Accutane** (Isotretinoin) in the last 6 months? Yes _____ No _____

Aesthetic/Skincare History

Have you used **tanning beds** in the last 4 weeks? Yes _____ No _____

Have you had unprotected sun exposure in the last 4 weeks? Yes _____ No _____

Are you planning to have sun exposure in the next 2 weeks? Yes _____ No _____

Do you currently use depilatories or wax ? Yes _____ No _____

Have you had a chemical peel within last 2 weeks? Yes _____ No _____

Do you have regular Botox/Dysport or any dermal filler injections? Yes _____ No _____

Have you recently had any facial resurfacing or facial surgery? Yes _____ No _____

Describe _______________________________________ When ___________________

Have you had hair removal or Photorejuvenation? Yes _____ No _____

What kind of skincare products are you using? __________________________________

Patient Name (print) ____

Patient Signature X________________________________ Date X____________