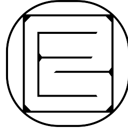


EMILY ROCKWELL

SKIN CLINIC

NEW PATIENT FORM

Name:____ Today's Date:_______/________/_________

DOB:_______/_______/___________ Age:__________

Address: ____

City:____ State: ___________ Zip Code: _____________

Home Phone: (_________)___________-_____________ Cell Phone: (_________)___________-_____________

Email:____

Occupation: ____ Employer:_________________________________

Contact Preference (please circle): Home Phone / Cell Phone / Text / Email / Mail

Emergency Contact/Relationship:____

Emergency Contact Phone: (________)__________-_____________

How did you hear about us?____

MEDICAL HISTORY

Do you have any medical conditions? Y / N

If so, please explain:

____

____

____

Do you have any allergies? ____

Are you pregnant or trying to become pregnant? Y / N Are you Nursing? Y / N

Do you have a muscle or nerve condition (ex: ALS or Lou Gehrig's disease, Multiple Sclerosis, myasthenia gravis, Lambert-Eaton Syndrome) Y / N

Do you have an Autoimmune Disease (ex: Rheumatoid Arthritis, Lupus, Crohn's)? Y / N

Do you have any Neurological Disorders such as Epilepsy? Y / N

Do you have a Thyroid Condition? Y / N

Do you have any Viral Concerns such as HIV or Hepatitis? Y / N

Do you Bruise easily? Y / N Do you scar or keloid? Y / N

Do you have poor wound healing? Y / N

Have you EVER had a cold sore? Y / N

If yes, provide Pharmacy name, number and current dosage: **(Lip filler and/or micro needling patients need to provide this information.)**

____

MEDICATIONS

Please list any medications you are taking, including prescription, nonprescription medications, and supplements:

____

____

Are you taking an anti-inflammatory / blood thinning medication / supplements, such as Aspirin, Advil, Ibuprofen, Motrin, Aleve, Coumadin, Plavix, Fish Oil, Vitamin E, St John's Wort, Ginkgo Biloba, Flax Oil, Cod Live Oil, or Niacin? Y / N (please circle)

If so, how often (please circle)? Daily / As needed / As prescribed by my Physician

Have you ever taken or currently prescribed Accutane or Spironolatone? Y / N

If yes, when, dosage and prescriber: ____

Are you currently taking or using Nicotinamide? Y / N

If yes, please specify what you are using: ____

Are you taking oral contraceptives? Ie: IUD, birth control, etc. Y / N

Specify: ____________________________________

Any recent changes to or from your contraceptive treatment? Y / N

If yes, please specify change and when: ____

Any changes to your skin noticed in menopause? Y / N or N/A

Specify: ____

Are you undergoing any hormone replacement therapy? Y / N or N/A

Specify: ____

SURGICAL HISTORY

Have you previously had Plastic Surgery to your Face/ Neck? Y / N

If so, what surgery, and when?

____

Are you currently considering Plastic Surgery to your Face/Neck? Y / N

If so, what surgery? ____

DENTAL HISTORY

Have you had recent dental work or in the past month? Y / N

Please circle those that apply:

Cleanings Root Canal Implant Crown

DERMATOLOGICAL HISTORY

Do you have melanoma or suspicious lesions? Y / N

If yes, please specify where and when diagnosed: ___________________________________

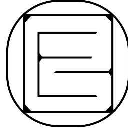
Do you see another provider for your skin? Y / N (Dermatologist/Aesthetician)

If yes, what treatments have you had or plan to have? ________________________________

Do you receive regular skin checks? Y / N

Do you plan to have additional treatments on your skin? (Lasers, Microblading, Hair Removal, Tattoo Removal)

____



EMILY ROCKWELL

SKIN CLINIC

AESTHETIC QUESTIONNAIRE

Name:____ Today's Date:_______/________/_________

Interests/Concerns:

- ☐ **Botox** – Fine lines & Wrinkles, Crows feet, Forehead, Eleven lines, Gummy Smile, Neck Lines, Bunny Lines, Lip Lines.
- ☐ **Dermal Fillers** – Loss of Volume in Mid to Lower Face (Cheeks, Nasolabial folds, Marionette lines, Lips, Facial contouring, Chin, Jawline).
- ☐ **Kybella** – Submental Fullness or "Double Chin."
- ☐ **Vampire Facial** – Microneedling with Platelet rich plasma (PRP) for skin tightening, scaring, fine lines.

What bothers you most?

____

____

Have you previously had **Botox** injections? Y / N

When was your last treatment:____

What areas were treated:____

Were you happy with your results?____

Have you previously had **Dermal Filler** Injections? Y / N

When was your last treatment:____

What areas were treated:____

What type of filler was used (ex: Juvederm, Voluma, Volbella, Restylane)

____

Were you happy with your results? Y / N If no, why:

____

Have you previously had **Microneedling**? Y / N

When was your last treatment? __________________________

What area was treated? ________________________________

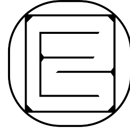
Was PRP used and/or injected? Y / N

Were you happy with the results? Y / N

Are you a Brilliant Distinctions Member? Y / N   Member #______________________

If you wish to become a member, please download the Brilliant Distinctions App to your phone

* * * Rewards must be in coupon form, **prior to your appointment**, allowing them to be applied to that day's service.



EMILY ROCKWELL

SKIN CLINIC

SKIN QUESTIONNAIRE

Name:____ Today's Date:_______/________/_________

Describe your skin (please circle):

Dry to Normal   Normal   Normal to Oily   Oily

List your primary concerns with your skin (Please circle):

Wrinkles   Dark spots(face/body)   Redness   Acne   Dryness   Texture

Large Pores   Dark Circles under the eyes   Cellulite   Stretch marks   Eczema

Other: ____

What have you done in the past to address your skincare concerns: (Circle)

Retinol   Dermaplaning   Laser   Hydroquinone   Facials   Peels

Did this improve your skin?   YES   NO

Do you currently use SPF on your face? Y / N   How often/when? ______________________________________

Have you had any recent tanning bed or sun exposure that changed the color of your skin? Y / N

If yes, please specify: ____

Does your job require you to work outside Y / N   Do you currently have an active sunburn? Y / N

Have you experienced a bad sunburn on your face in the last 6 months? Y /N

Have you ever had an allergic reaction to any of the following? (Please circle all that apply)

Cosmetics   Fragrances   AHA's

Retinol   Hydroquinone

Sunscreens   Latex

How many skin care products do you use a day? ______

Do you currently have monthly Medical Grade facials and or peels? Y / N

If yes, please specify: ____

____

Have you ever had a Medical Grade facial and or peel? Y / N

If yes, please specify: ____

Describe your lifestyle and work environment (ie: I spend a lot of time in the sun, like to tan, out publicly a lot? ...)

____

____

Describe your AM routine (Products and amount used ie: " I wash my face with Obagi cleanser/dime size amount...)

____

____

____

____

Describe your PM routine:

____

____

____

____