ReviveMD Medical Group

NEW COSMETIC PATIENT INTAKE FORM/EXISTING COSMETIC UPDATE FORM

Patient Name:_____Date_____DOB:_____

Please check all of the procedures you're interested in obtaining information on.

- ☐ **Hyaluronic Acid fillers: Restylane, Juvaderm, Radiesse**
- ☐ **Neuromodulators; Dysport, Botox, Xeomin**
- ☐ **Latisse**
- ☐ **Hydroquinone 4%**
- ☐ **Retin A (.025%, .05% or 0.1%), refissa**
- ☐ **Sculptra**
- ☐ **Ultherapy**
- ☐ **Enlighten Laser (Tattoo Removal)**
- ☐ **Pico Genesis**
- ☐ **Laser Hair Removal**
- ☐ **Laser Genesis**
- ☐ **KTP (laser)**
- ☐ **PRP (platelet rich plasma)**
- ☐ **Kybella**
- ☐ **Laser Vein Removal**
- ☐ **truSculpt**
- ☐ **Secret (micro-needling with radio frequency)**

General Health Questions

Are you pregnant?

- ☐ **Yes**
- ☐ **No**

Are you breastfeeding?

- ☐ Yes
- ☐ No

What was the date of your last menstrual cycle?_____

What was the date of your last sun tan?_____

When was the last time you had a spray tan?_____

Have you taken Accutane?

- ☐ Yes If yes, what was the date of your last dose?_____
- ☐ No

Do you have any current medical conditions that require you to be under a physician's care?

- ☐ Yes
- ☐ No

If yes, please list the specific conditions.

_____
_____

Are you currently taking any medications (include vitamins, supplements and herbs)?

- ☐ Yes
- ☐ No

If yes please list.

_____
_____

Do you have allergies to any medications?

- ☐ Yes
- ☐ No

If yes, please list and note reaction.

_____
_____

Do you have any allergies or sensitivity to the following items?

- ☐ Lidocaine
- ☐ Visine
- ☐ Benzocaine
- ☐ Latex
- ☐ Cow's Milk Protein
- ☐ Skin Allergies
- ☐ Tetracaine

Do you take any Blood Thinner's (i.e. aspirin, coumadin, lovenox….)

- ☐ Yes
- ☐ No

Do you have a history of skin cancer?

- ☐ Yes
- ☐ No

Are you currently under the care of a dermatologist?

- ☐ Yes
- ☐ No

If yes, please list why and the name of the physician

_____

_____

Please list any history of cosmetic surgeries/procedures

_____

_____

Do you have a history of anaphylaxis?

- ☐ Yes
- ☐ No

Do you have a history of abnormal intraocular pressure?

- ☐ Yes
- ☐ No

Do you have a history of macular edema?

- ☐ Yes
- ☐ No

Are you currently using Lumigan?

- ☐ Yes
- ☐ No

Do you have any implantable devices (i.e. pacemaker, metal implants, stimulators….)

If yes, please explain

_____

_____

_____ _____

Patient print name Date

_____

Patient signature