WELLSKIN MED SPA
OFFICE REGISTRATION

PATIENT INFORMATION						
Last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Home Number: ( )	Work Number: ( )	Mobile Number: ( )	**Birth date:** / /	Age:	Sex: ❑ M ❑ F	
Preferred number to contact you at:						
Is it important to be discreet: ❑ Yes ❑ No						
Address: Email:						
PO Box/Apt/Suite	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone number: ( )				
Name & number of emergency contact:						
Who may we thank for referring you: ❑ Dr. Neurohr ❑ Website ❑ Yellow Pages ❑ Friend _____ ❑ Other _____						

MEDICAL HISTORY					
Have you seen a dermatologist in the last year? ❑ Yes ❑ No					
Dermatologist's Name: Phone Number: ( )		Condition: Date last treated:			
If you are currently using any of the following medications/products, please check below:					
❑ Retin-A/Renova	❑ Topical Vit. C	❑ Glycolic-Acid	❑ Alpha Hydroxy Acid	❑ Accutane	Date used last:

MEDICATIONS		
DRUG ALLERGIES: (Include topical meds)		
Name the Drug	Reaction You Had	
CURRENT MEDICATIONS: (Include OTC meds)		
Name the Drug	Strength	Frequency Taken

SKIN CLASSIFACTION AND QUESTIONARE

Ethnicity: ❑ Caucasian ❑ African – American ❑ Hispanic ❑ Asian ❑ Other _____

Fitzpatrick Scale:
(circle one) **Type I** – very white skin, always burns **Type II** – white skin, usually burns **Type III** – olive skin, sometimes burns

Type IV – brown skin, rarely burns **Type V** – dark brown skin, rarely burns **Type VI** – black skin, never burns

Are you on hormone replacement therapy? ☐ Yes ☐ No If Yes, please list:	
Have you ever taken birth control pills? ☐ Yes ☐ No If Yes, please list:	
Do you have hyper-pigmentation (melasma/brown spots)?	☐ Yes ☐ No
Do you have facial wrinkles and age lines?	☐ Yes ☐ No
Do you sunbathe or participate in outdoor activities?	☐ Yes ☐ No
Do you use artificial sunlight?	☐ Yes ☐ No
Do you smoke?	☐ Yes ☐ No
Do you wear contact lenses?	☐ Yes ☐ No
Do you have acne?	☐ Yes ☐ No
If Yes, please list any medications used to control your acne:	
Have you ever had Herpes (cold sores)?	☐ Yes ☐ No
If Yes, when was your last out-break:	
Do you have a history of seizures or other neurological disorders?	☐ Yes ☐ No
Last date of skin waxing or electrolysis:	

Please state if you have ever had any of the following:

PROCEDURE	DATE
Cosmetic Surgery:	
Laser Resurfacing:	
Chemical Peels:	

What do you wish to gain from having cosmetic/aesthetic procedures?

Is there anything we should know before beginning your treatment?

I authorize and consent to the taking of photographs related to my clinical condition, and hereby grant Neu Aesthetic unrestricted authority to use any of these photographs in connection with this case for scientific or teaching purposes with the understanding that my name shall not be given in any of these.

Initials: _____ (must initial for consent of photos)

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____