

# ADVANCED Aesthetics *by Wichita Clinic*

9211 E. 21<sup>st</sup> St. / Wichita, KS 67206 / 316-609-4440  
www.wichitaclinicaesthetics.com

## ADVANCED AESTHETICS HISTORY FORM

This is a confidential record and will be kept in your Advanced Aesthetic chart only.  
Information will not be released without your authorization.

Elective Cosmetic procedures performed in Advanced Aesthetics will not be filed to insurance.

Today's Date: \_\_\_\_\_ Patient Social Security #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ Patient's Home #: (\_\_\_\_\_) \_\_\_\_\_  
Sex: M \_\_\_ F \_\_\_ Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Reason for Visit/ Main Cosmetic Concerns: \_\_\_\_\_

How did you hear about us?

- Website  Family/Friend  Newspaper  Women's Fair  Magazine  Phone Book  Physician Referral  
 Other (Please explain): \_\_\_\_\_

### **PAST COSMETIC HISTORY**

Please place an 'x' in front of any issue that pertains to your history

Prior cosmetic procedures:    \_\_\_ Botox®                            \_\_\_ Fillers (Collagen, Restylane®)  
   \_\_\_ Laser Resurfacing            \_\_\_ Intense Pulse Light Rejuvenation  
   \_\_\_ Chemical Peels                \_\_\_ Laser Treatment for Hair Reduction  
   \_\_\_ Laser vein treatment        \_\_\_ Schlerotherapy  
   \_\_\_ Microdermabrasion

Use of Retin A or topical retinoids? \_\_\_ Yes \_\_\_ No  
History of use of Accutane: \_\_\_ Yes \_\_\_ No, If yes, when? \_\_\_\_\_  
Are you presently using Accutane? \_\_\_ Yes \_\_\_ No.

### **PAST SKIN HISTORY**

Please place an 'x' in front of any issues that applies to your history

\_\_\_ Hypertrophic or keloidal scarring  
\_\_\_ History of fever blisters or Cold Sores (herpes simplex)  
\_\_\_ History of sun tanning or indoor tanning.  
\_\_\_ History of sun sensitivity (lupus erythematosus, polymorphous light eruption, solar urticaria)

Do you routinely use sunscreens? \_\_\_ Which SPF? \_\_\_\_\_ Face and body sunscreen? \_\_\_\_\_  
Any personal history of skin cancer? \_\_\_\_\_ Family history of skin cancer and who? \_\_\_\_\_

Please place an 'x' in front of any issues that applies to your history

How do you tan? \_\_\_ burn \_\_\_ usually burn \_\_\_ burn then tan \_\_\_ usually tan \_\_\_ always tan  
Your skin is: \_\_\_ oily \_\_\_ dry \_\_\_ combination \_\_\_ sensitive \_\_\_ not sure  
History of: \_\_\_ acne \_\_\_ pimples \_\_\_ blackheads \_\_\_ birthmark \_\_\_ pregnancy mask  
Skin allergies: \_\_\_ cosmetics \_\_\_ fabrics \_\_\_ fabric cleansers \_\_\_ fragrances \_\_\_ latex

## GENERAL MEDICAL HISTORY

Please place an 'x' in front of any issue that pertains to your history

1. Within the last year have you been under a physician's care? Yes\_\_\_\_ No\_\_\_\_ Why \_\_\_\_\_
2. Within the last year, have you been under a dermatologist's care? Yes \_\_\_\_No \_\_\_\_Why \_\_\_\_\_
3. Within the last nine months, have you undergone any surgery? Yes\_\_\_\_ No\_\_\_\_  
If yes, specify \_\_\_\_\_
4. Have you had any of these health problems in the past or present? (*circle all that apply*)  
Cancer Diabetes Epilepsy Heart problem Hormone imbalance Spinal injury Thyroid condition Varicose veins
5. **Are you allergic to latex?** Yes\_\_\_\_ No\_\_\_\_ Do you wear contact lenses? Yes\_\_\_\_ No\_\_\_\_
6. Have you ever had any reaction to the following? (*circle all that apply*)  
Iodine Pollen Food Hydroxy acids Animals Sunscreens Aspirin Other \_\_\_\_\_
7. Do you exercise regularly? Yes\_\_\_\_ No\_\_\_\_ Do you follow a restricted diet? Yes\_\_\_\_ No\_\_\_\_
8. Do you have metal implants? Yes \_\_\_\_ No \_\_\_\_
9. Do you have regular sleep patterns? Yes \_\_\_\_ No \_\_\_\_

**Social history: Smoke** Yes \_\_\_\_ No \_\_\_\_ **List alcohol intake amount and frequency:** \_\_\_\_\_

**Allergies** (List medications and reaction): \_\_\_\_\_

**List any medications that you take:**(prescribed/over-the-counter/herbal supplements): \_\_\_\_\_

**Are you currently using a blood thinner product?** \_\_\_\_\_(which one: Aspirin, NSAIDS, Coumadin, Heparin, other?)

**Immunosuppressive Drugs?** \_\_\_\_\_ (which ones and for what reason?) \_\_\_\_\_

### Female patients only:

1. Are you taking oral contraception? Yes\_\_\_\_ No\_\_\_\_
2. Are you pregnant? Yes \_\_\_\_ No \_\_\_\_ or trying to become pregnant? Yes\_\_\_\_ No\_\_\_\_
3. Are you lactating? Yes\_\_\_\_ No\_\_\_\_
4. Are you using Hormone Replacement Therapy? Yes \_\_\_\_ No \_\_\_\_ Type \_\_\_\_\_
5. Do you have regular periods? Yes \_\_\_\_ No \_\_\_\_
6. Are you due to start your menstrual period? Yes \_\_\_\_ No \_\_\_\_

### Male patients only:

1. What is your current shaving system? Electric\_\_\_\_ Wet shave\_\_\_\_
2. Do you experience irritation from shaving? Yes \_\_\_\_ No\_\_\_\_
3. Do you experience ingrown hairs? Yes\_\_\_\_ No\_\_\_\_

## AESTHETICIAN AND SKIN CARE HISTORY

Please list skin care products you are currently using: \_\_\_\_\_

### SKIN

1. With what temperature of water do you cleanse? Cool\_\_\_\_ Warm\_\_\_\_ Hot\_\_\_\_
2. Do you have any special skin problems pertaining to your face or body? Yes\_\_\_\_ No \_\_\_\_  
If yes, please specify \_\_\_\_\_

### EXFOLIATION HISTORY

1. Do you use an acne medication? Yes\_\_\_\_ No\_\_\_\_  
If you use acne meds which medication and when was the last time used? \_\_\_\_\_
2. Are you currently using any products that contain the following ingredients? (*circle all that apply*)  
Glycolic acid Lactic acid Exfoliating scrubs Hydroxy acid product Vit. A derivatives (i.e., retinol)

### MOISTURE / HYDRATION

1. How much plain water do you consume daily? \_\_\_\_\_
2. Do you ever experience these conditions on your skin? (*circle all that apply*)  
Flakiness Tightness Obvious dryness

**CAPILLARY ACTIVITY**

1. Do you burn easily in moderate sunlight? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Do you blush easily when nervous? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Do you have a tendency to redness? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Do you suffer from sinus problems? Yes \_\_\_\_\_ No \_\_\_\_\_

**OIL SECRETION**

1. Do you ever experience oily shine throughout day? Yes \_\_\_\_\_ No \_\_\_\_\_ Occasionally \_\_\_\_\_
2. Do you ever experience skin breakouts? Yes \_\_\_\_\_ No \_\_\_\_\_ Occasionally \_\_\_\_\_

**NERVE ACTIVITY**

1. Do you drink caffeinated beverages (coffee, tea, soft drinks)? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_
2. Do you ever experience a burning, itching, sensation on you skin? Yes \_\_\_\_\_ No \_\_\_\_\_
3. What is your pain threshold? Low \_\_\_\_\_ Med \_\_\_\_\_ High \_\_\_\_\_
4. Have you ever experienced claustrophobia? Yes \_\_\_\_\_ No \_\_\_\_\_
5. What type of massage pressure do you prefer? Soft \_\_\_\_\_ Med \_\_\_\_\_ Firm \_\_\_\_\_

Would you like your Primary Care Physician to be notified of this visit/procedure?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, who is your Primary Care Physician? \_\_\_\_\_

The information on this form is correct to the best of my knowledge. I am aware that claims will not be filed to my insurance and that all costs that are accrued will be my responsibility.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_