

Estetica Skin and Laser Centre

Division of Plastic Surgical Services, Dr. Tom Lois

Client Information

Please Print

DATE: _____

NAME: FIRST _____ MIDDLE _____ LAST _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BIRTHDATE: ___/___/___ AGE: _____ GENDER (circle one) MALE FEMALE

HOME: (_____) _____ WORK: (_____) _____ CELL: (_____) _____

E-MAIL ADDRESS: _____

WOULD YOU LIKE TO BE ON OUR E-MAIL LIST FOR MONTHLY SPECIALS? YES NO

OCCUPATION: _____ EMPLOYER: _____

SPOUSE OR CONTACT PERSON: _____

HOME: (_____) _____ WORK: (_____) _____ CELL: (_____) _____

PREFERRED METHOD OF CONTACT: (please check one of the following)

HOME _____ CELL _____
WORK _____ E-MAIL _____

MAY WE LEAVE A MESSAGE? YES _____ NO _____

REFERRED BY: (please specify in the space provided)

SELF _____	RELATIVE _____
AJC _____	PATIENT _____
MAGAZINE _____	SALON _____
YELLOW PAGES _____	EMPLOYEE _____
FRIEND _____	OTHER _____

REASON FOR TODAY'S VISIT: _____

LISTED BELOW ARE OUR SKIN CARE SERVICES, PLEASE CHECK ALL THAT YOU ARE INTERESTED IN.

FACIALS _____	LASER _____	WAXING _____
PEELS _____	EPIFACIAL _____	EUROPEEL _____
PIGMENTATION _____	LEG VEIN TREATMENT _____	VESSELS TREATMENT _____
PLASTIC SURGERY _____	BODY TREATMENTS _____	JANE IREDALE _____
ENVIRON SKIN CARE _____	BIOMEDIC SKIN CARE _____	SKINCEUTICALS _____

SIGNATURE: _____

DATE: _____

*** Please note, we will need to make a copy of your driver's license for your patient chart, for identity purposes.

Estetica Skin and Laser Centre

Division of Plastic Surgical Services, Dr. Tom Lois

PATIENT PROFILE

Please Print

Date: _____ Aesthetician: _____

What type of work do you do? _____

Do you participate in vigorous aerobic activity and how often? _____

Do you smoke? _____ Packs per week and for how long: _____

Are you currently pregnant or lactating? _____ Have you ever been pregnant? _____

During pregnancy, did you experience hyper pigmentation? _____

Areas: _____ Comments: _____

Do you currently have regular periods? _____

Are you currently going through menopause? _____

Do you wear contact lenses? _____ Do you use tanning booths? _____

Do you currently have a sunburn or windburn? _____ Area: _____

Do you currently have waxing / electrolysis treatments? _____ Area: _____

Are you currently using Biore' or other acne strips? _____ Area: _____

Are you currently using Retin-A, Renova or Differin? _____ Strength: _____

How frequently? _____ Area: _____ For how long? _____

Are you currently using Accutane? _____ For how long? _____

Are you currently having microdermabrasion? _____ For how long? _____

Have you ever had any injectable fillers (collagen, restylane, radiance, etc)? _____ If so, when? _____

Do you have regular Botox injections? _____ If so, when? _____

Have you ever had a peel? _____ Date of last peel? _____

Type of peel? _____ Describe your reaction? _____

Have you recently had facial surgery? _____ Type and date: _____

Have you ever had laser resurfacing? _____ Type and date: _____

Do you develop cold sores or fever blisters? _____ Last breakout: _____

ARE YOU ALLERGIC OR SENSITIVE TO ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY

Milk	Aloe Vera	Grapes	Perfumes	Hydroquinone
Citrus	Apples	Aspirin	Latex	

Any other allergies? _____

Are you sensitive to alcohol-based products? _____

Are you taking any medications at this time, over-the-counter or RX? _____

DESCRIBE YOUR SKIN FROM THE FOLLOWING CHOICES, PLEASE CIRCLE ALL THAT APPLY.

Thick	Saggy	Normal	Combination	Acne Prone
Thin	Firm	Dry	Oily	Comedones

Milia
Cystic
Breakouts
Scarred
Large Pores

Small Pores
Flolid
Rosacea
Eczema
Freckled

Sun-damaged
Uneven/Blotchy
Mature
Wrinkled
Patchy Dryness

Sallow
Melasma
Perfume-stained
Hypopigmentation
Hyperpigmentation

Psoriasis
Dehydrated
Asphyxiated
Broken Capillaries

WHICH OF THE FOLLOWING DO YOU CONSIDER YOUR SKIN TO BE? PLEASE CHECK ONE OF THE FOLLOWING

Sensitive _____

Resilient _____

Not Sure _____

EYE COLOR:

Blue _____
Green _____

Gray _____
Light Brown _____

Medium Brown _____
Dark Brown _____

NATURAL HAIR COLOR:

Blonde _____
Red _____

Light Brown _____
Medium Brown _____

Dark Brown _____
Black _____

Gray/Silver _____

SKIN TONE:

Pale/ white _____
Light _____
Medium _____

Reddish _____
Freckled _____
Light Olive _____

Medium Olive _____
Dark Olive _____
Light Brown _____

Medium Brown _____
Dark Brown _____
Soft Black _____

Black _____
Sallow _____

What is your ethnicity? _____

Are you using glycolic / AHA home care products? _____ Please list: _____
How does your skin react to them? _____

Have you ever used any products that cause a bad reaction? _____

What is your daily home care regimen? _____

What are the cosmetic improvements you would like to see in your skin? _____

Photos taken today? _____ Areas: _____

Any comments: _____

Aesthetician Signature: _____