NUVEAU
Medical Aesthetics

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Medical Director

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NAME:

ADDRESS: ______________________________

CITY: ______________ STATE: ______________ ZIP: __________

HOME PHONE: ______________ WORK PHONE: ______________

MOBILE PHONE: ______________ EMAIL: ______________

DATE OF BIRTH: ______________ AGE: __________ SEX: __________

How did you hear about NUVEAU Medical Aesthetics?
Friend (Name): ______________ Newspaper: ______________
NUVEAU Employee (Name): ______________ Magazine: ______________
Other: ______________ Web Site: ______________

How would you prefer to be reminded of your next appointment?

- ☐ E-Mail
- ☐ Home Phone
- ☐ Mobile Phone

Optional Questions:

1. What is your current primary skin care concern? ______________

   ____

2. How long have you had this concern? ______________

3. What do you hope to accomplish with the skincare professionals at NUVEAU? ______

   ____

4. Do you have sensitive skin? ☐ Yes ☐ No

   (If yes, please explain) ______________

5. Is your present skin concern becoming more pronounced? ☐ Yes ☐ No

   (If yes, please explain) ______________

6. Have you ever experienced an allergic reaction to skin products? ☐ Yes ☐ No

   (If yes, please explain) ______________

7. Have you undergone any cosmetic medical procedures in the last 6 months? ☐ Yes ☐ No
   If yes, when and by what methods (ex: Botox, laser work, microdermabrasion)?

   ____

8. Do you have recurring skin problems? ☐ Yes ☐ No
   Are you experiencing them today? ☐ Yes ☐ No

   ____

9. Have you been treated for dermatological conditions in the past? ☐ Yes ☐ No
   If yes, when and by what methods? ______________________________

   ____

10. Are you currently taking any medications for skin problems? ☐ Yes ☐ No
    If yes, which medications? ______________________________

11. Do you have a history of keloid scarring? ☐ Yes ☐ No

12. Do you develop dark spots easily after trauma or break to the skin?
    (Ex. acne breakouts, cuts, insect bites, etc.) ☐ Yes ☐ No

13. Have you ever had pigmented lesions treated? ☐ Yes ☐ No
    If yes, what type(s) and where? ______________________________

14. What Products do you currently use? Please list brand names next to products used.
    Cleanser: ______________________
    Exfoliant: ______________________
    Toner: ______________________
    Moisturizer: ______________________
    Sunscreen: ______________________
    Treatment Serum: ______________________
    Eye/Gel Cream: ______________________
    Other: ______________________

15. Which of these delivers the best results? Why? ______________________

    ____

16. Are you pregnant, nursing, or planning pregnancy soon? ☐ Yes ☐ No

    ____

17. Do you have a history of any of the following?

    ☐ Heart Disease
    ☐ High Blood Pressure
    ☐ Cold sores
    ☐ Easy Bruising
    ☐ Previous Skin Injuries
    ☐ Diabetes
    ☐ Leg Clots (DVT)
    ☐ Bleeding Disorders
    ☐ Dark spots after pregnancy (melasma)
    ☐ Skin Cancers / suspicious moles

18. Do you have any allergies to oral or topical medications? ☐ Yes ☐ No
    If yes, which ones? ______________________________

19. Do you have any allergies to topical or local anesthesia? ☐ Yes ☐ No
If yes, which one(s)? ____________________

20. Do you take or have taken any of the following medications?

- ☐ Aspirin
- ☐ Hormones / Birth Control
- ☐ Thyroid medications
- ☐ Sedatives / Tranquilizers
- ☐ Antibiotics
- ☐ Accutane
- ☐ Anti-coagulants (blood thinners/ Coumadin)
- ☐ Appetite Suppressants (diet pills)
- ☐ Insulin
- ☐ Steroids
- ☐ Herbal preparations (ex. St. John's Wort)
- ☐ Retin-A/Retinol

Please elaborate: ____________________

21. What is your daily consumption of alcohol? ____________________
22. What is your daily consumption of tobacco? ____________________
23. Do you wear contact lenses? ☐ Yes ☐ No
24. Do you tan under the sun or in a tanning booth? ☐ Yes ☐ No
25. Do you use sunscreen or sun block on a daily basis? ☐ Yes ☐ No
26. Do you use chemical sun tanning lotions? ☐ Yes ☐ No
27. Are you planning a holiday in the sun? ☐ Yes ☐ No
28. Do you live in an urban environment? ☐ Yes ☐ No
29. Have you had dental work in the last 6 months? ☐ Yes ☐ No
30. Have you had any major illness in the last 6 months? ☐ Yes ☐ No
31. What is your average daily water Intake? (glasses per day) ____________
32. What types of foods do you tend to eat regularly? ____________________

____

I certify that the answers I provided are true to the best of my knowledge.

____________________ ____________________

Patient Signature Date