NEW YORK SKIN&VEIN CENTER

Date: _____

Name _____ **Date of Birth** ___ /_____/____

Address _____ **ZIP** _____

Cell Phone _____ **Home Phone** _____

Personal Email _____

Marital Status: Single Married Widow Attached **Children:** None * If Yes # _____ * Grandchildren #_____

Occupation _____ **Employer** _____

Emergency Contact Name and Phone _____

How did you hear about us? Internet Search Newspaper Ad Newsletter Word of Mouth Facebook IG

Name of Person who referred you _____

CIRCLE AREAS YOU WOULD LIKE TO DISCUSS
OR ARE INTERESTED IN IMPROVING (NOW OR IN THE FUTURE):

FACE: Acne Scars Broken blood vessels Large pores Wrinkles Sagging skin Rosacea Melasma Thin lips Lipstick lines Dark eye circles Uneven complexion/ Brown spots Hollow cheeks

NECK: Double chin Sagging skin Broken blood vessels Wrinkles

BODY & LEGS: Brown spots Acne Body fat Cellulite Sagging skin Scars Tattoo removal Varicose or Spider veins Fungal nails Stretch marks Excess underarm sweating

FEMININE: Vaginal dryness Overactive bladder Urinary incontinence Painful intercourse

HAIR: Unwanted/ Excess - Where _____

Loss of hair – Where _____

Other: _____

CIRCLE ANY SKIN TREATMENTS YOU HAVE HAD IN THE PAST:

Toxins: (Botox Dysport Xeomin**) Fillers:** (Restylane Juvederm Radiesse Sculptra Bellafill Silicon) Silicon Microneedling Chemical Peels Laser or Skin Resurfacing Ultherapy Thermage CoolSculpting Laser Hair Removal Electrolysis Permanent Make-up Leg Veins- Laser / Sclerotherapy Facelift Neck Lift Eyelid surgery Fat injections Liposuction Tummy Tuck Breast Implants/Lift

List your Current skin care products: Cleanser/Soap:

Retin A/Retinols:

Moisturizers:

Sunscreen/Makeup/ Other (home peels, etc)

List any past or current **medical problems and surgeries:**

Current Medications/Hormones/Vitamins/Herbs/ OTC meds:

List any allergies to Medications, Environmental, Latex, etc:

Who is your Doctor/Provider/Dermatologist (list all):

PAST SKIN HISTORY:

Have you ever been treated with **Accutane** and when:

Ever been diagnosed with **Psoriasis Eczema Melasma Rosacea Skin Cancer Keloids?**

If yes, please share the details:

Do you **smoke?** YES NO If yes, how much?

Have you ever had **Cold sores or Fever blisters**? If yes, how treated?

Do you actively **tan, use tanning beds** and/or use self-tanning lotions?

After an injury or surgery, do your **scars** get hard, lumpy, red, get darker?

Please note any other skin health concerns or medical issues that has not been listed that we would need to know about:

What do you do for fun or recreation or sports or exercise?

Signature _____ Date_____
Reviewer _____