Krueger
AESTHETICS

COSMETIC INTAKE FORM

Name:_____DOB_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____

Email Address_____

Referred By_____

Reason for Visit_____

Medical History: Please circle all applicable, past and present.

Yes No Are you pregnant or breastfeeding?

Yes No Do you form thick raised scars from cuts or burns?

Yes No History of cancer or unusual moles?

Yes No History of Lupus?

Yes No Do you use Retin A or glycolic products?

Yes No Have you used Accutane?

Yes No Are you diabetic?

Yes No Cosmetic surgery or injections within the past 12 months (list below)

Yes No Recent steroid use?

Yes No Do you have any skin infections?

Yes No Do you get cold sores?

Yes No Do you have any drug allergies? Please list:_____

Yes No Pacemaker or metal in your body

Yes No Neuro-muscular disorders such as ALS, MS Guillian Barre?

Yes No Immunocompromised (cancer, HIV,etc)

Yes No Autoimmune System Disorder such rheumatoid arthritis, scleroderma?

Yes No Easy bruising or bleeding?

Yes No Do you smoke or use tobacco products?

Yes No Recent sunburns or waxing?

List any chronic medical conditions _____

Current medications, vitamin and supplements:_____

_____

Prior surgeries and procedures **including cosmetic treatments**:

_____

Signature _____Date_____