



Please introduce yourself...

Chart# _____

Name: _____ Today's Date: _____
(First Name) (Middle Initial) (Last Name)

Birth Date: ____ / ____ / ____ Age: ____ Male Female E-mail: _____
(Month) (Day) (Year)

Home Phone: () _____ Cell Phone: () _____

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Business Phone: () _____

Married? Yes No Spouse's Name: _____

In case of emergency, please contact:

Name: _____

Phone: () _____ Cell Phone: () _____

May we share your medical information with this person? Yes No

Please list anyone else we can share your medical information with: _____

Where did you hear about Ideal Image®?

Friend or Family Member, Name: _____

Physician Referred, Name: _____

Radio TV Billboard Magazine/Newspaper Internet Local Event Other _____

How do you preferred to be contacted? Phone E-mail Text Message

Would you like to receive special offers and promotions from Ideal Image® via e-mail? Yes No

What are your three favorite radio stations? _____

What are your three favorite web sites? _____

We do not sell any customer information to any third party. Neither do we provide any individually identifiable customer information to any third party except as follows: in response to subpoenas, court orders or legal process, in order to finalize a payment for services requested and agreed to with your personal Ideal Image® consultant. This information may be shared with your financial institution or credit card issuer as indicated.

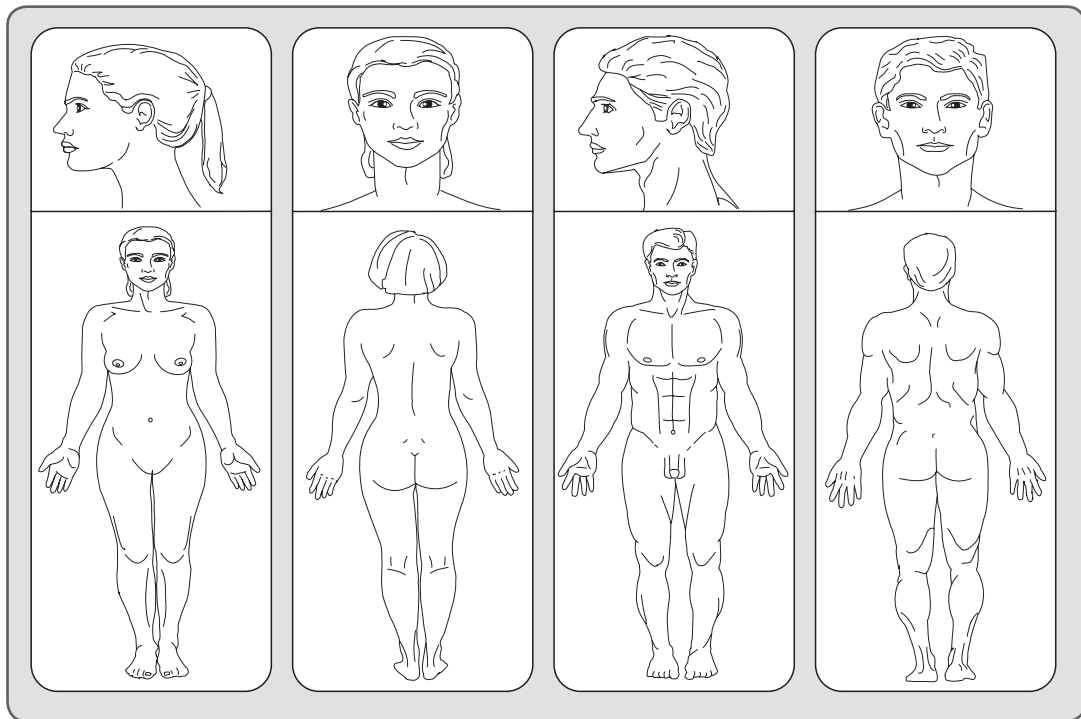
Name _____ Chart# _____

Please tell us about yourself...

Have you ever had laser treatments or Electrolysis? Yes No

Procedures/Areas treated: _____ Any complications? _____

Please Circle The Areas You Need Treated On The Diagram Below



In order to better establish your skin type, please tell us your race/ethnicity: _____

Please Check The Box That Best Describes Your Skin Type:

- Skin Type I Never tans, always burns (extremely fair skin, blonde hair, blue/green eyes)
- Skin Type II Occasionally tans, usually burns (fair skin, sandy/brown hair, green/brown eyes)
- Skin Type III Often tans, sometimes burns (medium skin, brown hair, brown eyes)
- Skin Type IV Always tans, never burns (olive skin, brown/black hair, dark brown/black eyes)
- Skin Type V Never burns (dark brown skin, black hair, black eyes)
- Skin Type VI Never burns (black skin, black hair, black eyes)

Is your skin sensitive? Yes No

Name _____ Chart# _____

Medical history

How would you describe your general health? Good Fair Poor

Have you had a major illness or been hospitalized within the last 5 years? Yes No

Please describe: _____

Are you currently using any medications? (Topical, Ingestible or Injectable) Yes No

List all medications and conditions: _____

Do you have acne? Yes No Are you taking Accutane? Yes No

Have you taken Accutane in the last 6 months? Yes No

Are you using Rogaine, Propecia, Minoxidil? Yes No If yes, please list: _____

Are you using steroids? Yes No

Have you ever had gold injections? Yes No Are you allergic to Latex? Yes No

Do you have any tattoos and/or permanent makeup? Yes No If yes, where? _____

Are you allergic to any medications? Yes No Please list: _____

Are you taking Aspirin, Advil, Motrin or any other over the counter medications? Yes No

List: _____

Are you taking any herbal or vitamin supplements? Yes No List: _____

Do you use tobacco? Yes No Type: _____

Do you consume more than two alcoholic beverages per day? Yes No

Have you ever had any of the following:

Skin Cancer or Pre-Cancer Yes No

What type: Basal Cell Dysplastic Nevus Squamous Cell Melanoma

If yes, when: _____ Where on the body: _____

Was it treated and how? _____

Name _____ Chart# _____

Have you ever had any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart Disease or Condition | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Implant (breast, other) |
| <input type="checkbox"/> Liver Disease/Hepatitis (A, B, or C) | <input type="checkbox"/> Keloid Scarring | <input type="checkbox"/> PCOS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Methemoglobinemia | <input type="checkbox"/> Vasculitis with/without skin involvement | <input type="checkbox"/> Hormone/Thyroid Disorder | <input type="checkbox"/> Respiratory Condition |
| <input type="checkbox"/> Abnormal Blood Pressure (high or low?) | <input type="checkbox"/> Connective Tissue Disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Lupus | <input type="checkbox"/> Transplant | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Allergy to Lidocaine or other "caines" | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eczema | <input type="checkbox"/> Eye Disease |
| <input type="checkbox"/> Pacemaker or Palpitations | <input type="checkbox"/> Oral Herpes or Cold Sores | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Sinus or Ear Trouble |
| <input type="checkbox"/> Breast Feeding Currently | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Skin Condition/MRSA/Infection | <input type="checkbox"/> Cancer |

Please describe or explain any of the above: _____

Have you ever had any surgical procedures? Yes No

Please describe: _____

Have you ever had any of the following treatments: Chemical Peel Laser Peel BOTOX® Fillers
 Glycolic Peel Microdermabrasion Cosmetic Surgery Other: _____

What skin care products are you using? (Cleanser, Moisturizer, etc.) _____

Do you use or have you ever used any of the following products? Retin A AHA Hydroquinone

Other: _____ Any reactions? _____

Is there any other information about your health that we should know? _____

WOMEN ONLY: Are you pregnant? Yes No Expected Delivery Date: _____ / _____ / _____

Are you trying to become pregnant? Yes No Are you currently nursing? Yes No

Are you taking oral contraceptives? Yes No Menstrual cycles regular Yes No

Patient Signature: _____ **Date:** _____ / _____ / _____

Person responsible for account (If under 18)

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

OFFICE USE ONLY:

Confirmed for treatment by: _____ Date: _____ / _____ / _____

Treatment Provider/Medical Director Signature