REYNOSO MD

Skin and Laser Center

Aesthetic Client Registration

(PLEASE PRINT)

Patient Name(first, middle, last)____ Date of Birth___________________

Mailing Address____

City______________________________ State_____________ Zip code__________ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other

Primary contact number to reach you______________________________ Ok to leave a message? ☐ Yes ☐ No

Secondary contact number_______________________________________ Ok to leave a message? ☐ Yes ☐ No

Secure Email Address______________________________________ Ok to contact you through email? ☐ Yes ☐ No

Emergency contact name and number____ Relationship___________

Race/Ethnicity____ Occupation__________________________________

How did you hear about us?____

What brings you in today?____

Do you have any chronic medical conditions? ☐ Yes ☐ No

If yes, please list____

Are you currently taking any medications that are prescribed, over the counter or any supplements? ☐ Yes ☐ No

If yes, please list____

Do you have any allergies to medications, herbal or natural supplements? ☐ Yes ☐ No

If yes, please list name and reaction____

Have you taken Accutane or Anticoagulants in the past 6months? ☐ Yes ☐ No

Do you have veneers on your teeth? ☐ Yes ☐ No

Do you have a history of cold sores, fever blisters or herpes I or II?* ☐ Yes ☐ No

**use of lasers and IPL can trigger an outbreak*

If yes, when was your last outbreak?____

Do you have a history of hyper and/or hypo-pigmentation? ☐ Yes ☐ No

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

Have you ever had skin treatments using a laser, microdermabrasion, chemical peels or injections? ☐ Yes ☐ No

If yes, please list ______________________________

What skin care products are you currently using?______________________________

____

Are you happy with your skin care products? ☐ Yes ☐ No

Do you or have you used any topical medications or creams such as Retin A, Renova, Tazorac, Differin, Obagi, Gold Therapy or any others? ☐ Yes ☐ No

If yes, please list______________________________

Do you have any permanent makeup or tattoos? ☐ Yes ☐ No

If yes, please list ______________________________

PLEASE TELL US ABOUT YOUR SKIN: (Check all that apply)

☐ Normal ☐ Dry ☐ Oily ☐ Acne ☐ Large Pores

☐ Melasma ☐ Hyper-pigmentation ☐Hypo-pigmentation ☐ Broken Capillaries

Natural Hair Color ______________________ Eye Color ______________________

Is there any additional information you would like to provide the medical staff/technician?

____

____

____

What are your skin care goals? ______________________________

____

Have you had any sun exposure in the last 4-6 weeks, including tanning beds, bronzing creams or spray-on tans?

☐ Yes ☐ No If yes, please specify______________________________

WOMEN ONLY:

Are you or could you be pregnant? ☐ Yes ☐ No Are your menstrual cycles normal? ☐ Yes ☐ No

Are you currently taking Birth Control? ☐ Yes ☐ No If yes, which brand? ______________________

Client Signature______________________________ Date______________

Witness ______________________________ Date______________