a practice by JOHN P. SCHILLING, MD
schilling
COSMETIC SURGERY & AESTHETICS

Medical Aesthetic Data Form

Clear Form

Complete - Print

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SchillingMedicalSpa.com

Patient ID: ←(FOR OFFICE USE) **Today's Date:**

Patient Name: _____ DOB: _____ Social Security #: _____

Address: _____

_____

Mailing Address (if different): _____

_____

EMERGENCY CONTACT Name: _____

EMERGENCY CONTACT Phone: _____

Relationship: _____

☐ Home: _____

☐ Cell: _____ CHECK PREFERRED ←CONTACT NUMBER

☐ Work: _____

Email Address: _____

Employer: _____

Occupation: _____

How did you hear about us? _____ If a friend, name? _____

Please tell us what you would like more information about:

- ☐ Facials - Facial Services
- ☐ Chemical Peels
- ☐ Home Skin Care Products
- ☐ Hyper-Pigmentation
- ☐ Rosacea
- ☐ Microdermabrasion
- ☐ Neurotoxins (e.g. Botox, Xeomin)
- ☐ Fillers (e.g. Juvéderm, Sculptra...)
- ☐ Laser Stretchmark Reduction
- ☐ Laser Skin Tightening/Anti-Aging
- ☐ Laser Hair Reduction
- ☐ Laser Vein Treatment
- ☐ Weight-Loss
- ☐ Liposuction
- ☐ Lipo-Abdominoplasty (Tummy Tuck)
- ☐ Facial Fat Grafting
- ☐ Buttocks Enhancement
- ☐ Breast Augmentation
- ☐ PDO Threads
- ☐ Kybella

Please check all that apply:

- ☐ Breast-feeding
- ☐ Arthritis
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Pressure
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Depression
- ☐ Edema
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ HIV / Aids
- ☐ Insomnia
- ☐ Numbness
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Spinal Problems
- ☐ Varicose Veins

List ANY operation, surgery, or serious illness that have required hospitalization:

Month/ Year	Operation or Illness	Complications (any)?

MEDICAL HISTORY

Have you ever had a cold sore or fever blister?	☐ NO	☐ YES
Are you sensitive to LATEX?	☐ NO	☐ YES
Are you currently pregnant or breastfeeding?	☐ NO	☐ YES / (IF NO), Please give date of Last Menstrual Period: _____
Are you attempting pregnancy?	☐ NO	☐ YES
Do you wear contacts or eyeglasses?	☐ NO	☐ YES, Specify: _____
ARE YOU CURRENTLY USING ANY ORAL MEDICATIONS?	☐ NO	☐ YES, Specify: _____
ARE YOU CURRENTLY USING ANY TOPICAL MEDICATIONS?	☐ NO	☐ YES, Specify: _____
Do you use birth control pills?	☐ NO	☐ YES, Specify: _____
Do you have any allergies?	☐ NO	☐ YES, Specify: _____

SKIN CARE PROFILE

Important Information for: Microdermabrasion, Facials, Chemical Peels, Injectables, Waxing, Laser or Light-Based Treatments

Have you ever taken Accutane? ☐ NO ☐ Yes, When _____ Dosage _____ Amt of time _____

Have you used Tretinoin (Retin-A)? ☐ NO ☐ Yes, Dosage (%) _____

Have you ever had any of the following procedures? Please give dates and any important details.

- ☐ Botox/Dysport _____
- ☐ Restylane/Radiesse/Other filler? _____
- ☐ Sculptra _____
- ☐ Comedone (blackheads) Extraction _____
- ☐ Laser _____
- ☐ Chemical Peels _____
- ☐ Facial Surgeries _____
- ☐ Number of Facials in last 12 months _____

Areas of Concern (Please check all that apply):

- ☐ Lines / Wrinkles
- ☐ Skin Elasticity
- ☐ Skin texture
- ☐ Acne Scars
- ☐ Even color Tone
- ☐ Skin Pigmentation
- ☐ Acne
- ☐ Skin Hydration
- ☐ Skin Disorder (list) _____
- ☐ Other Areas of Concern: _____

Current skin care products used: _____

_____

LASER HAIR REDUCTION & WAXING

Please list any previous LASER or LIGHT-BASED hair reduction/removal treaments you have received:

Area(s) Treated	Dates of Treatment	Type of Device Used	Results/Comments (any sensitivity?)

Other Hair Removal History:

	How often?	Last time (date):	List complications or sensitivity (if any):
☐ Waxing:			
☐ Tweezing:			
☐ Electrolysis:			
☐ Bleaching:			
☐ Shaving:			
☐ Other:			

Are you currently using any of the following tanning methods? (If so, please list last date used.)

	Last time (date):		Last time (date):
☐ Tanning Beds		☐ Airbrush Tanning	
☐ Outdoor Tanning		☐ Sunless Tan Lotions	

CONSENT AND SIGNATURE

I have listed all known medical/physical conditions, if there are any changes in the future, I will inform my PROVIDER at Schilling Cosmetic Surgery & Aesthetics, of any changes. I agree to pay for all services at time they are rendered.

I understand that when scheduling an appointment I am required to reserve the appointment with a Credit Card or Gift Card number and a 24 hour notice is required to avoid paying missed appointment fees. A $30 fee will be charged for all returned checks.

I acknowledge by my signature below that I have read and understand the above statements and give my permission to receive this and any further treatments at Schilling Cosmetic Surgery & Aesthetics. I confirm to the best of my knowledge that the answers I have given on both pages, are correct and, that I have not withheld any information that may be relevant to my treatment.

_____ _____

Signature Date today (please add additional date if information is updated)

OFFICE USE ONLY:

Date ENTERED: _____ Initials: _____ Date UPDATED: _____ Initials: _____

Date UPDATED: _____ Initials: _____ Date UPDATED: _____ Initials: _____