HEARTLAND AESTHETICA
CURATED BEAUTY

Consultation Form

Patient Name: ____ **Date:** _______________

Date of Birth: ___________ **Age:** _____ **Gender:** ______ **Preferred Language**: ____________

Address: ____

Phone Number: ____________________________ **E-mail:** _____________________________

Employer: ________________________________ **Occupation:** _________________________

Primary Doctor: _______________________________ **Referring Doctor**: ________________

How did you hear about us? (Circle One) **Website** **Facebook** **Instagram** **Patient Referral**

If patient referral, who may we thank for your business? __________________________________

Preferred Pharmacy: ____

Today I am interested in a consultation for the following (Circle all that apply)

Botox/Dysport
Fillers
Acne Scarring
Micro-Needling
Sclerotherapy (Spider veins)
Skin Care Products
Sunspots (BBL)
Halo / Profractional
Deep Resurfacing
Hair Removal
Vaginal Wellness
Other:

Have you been under the care of a physician or medical professional within the last year? **Y/N**

If Yes, please explain: ____

List all surgeries including cosmetic surgeries: ____

____

Last date of Cosmetic Treatment (MM/YY): ____

Do you have a history of cold sores? **Y / N** If Yes, list medication:__________________________

Have you taken any prescribed blood thinners, ibuprofen, or Aspirin in the last 48 hours? **Y / N**

If Yes, please list: ____

Do you have a history of skin cancer? **Y / N** If yes, please explain: ___________________________

Do you have any piercings, tattoos, or permanent cosmetics? **Y / N** Location: ___________________

Do you use Retin-A, Renova, Adapalene, Hydroxyl Acid, Diferin, Glycolic Acid, AHA, Salicylic Acid, Vitamin A derivative products? **Y / N**

If yes, please list and describe last time used: ____

Do you use Acne Medications? **Y / N** If yes please list: ____________________________________

Have you ever used Accutane? **Y / N** If yes, last used:_____________________________________

Are you pregnant, or breastfeeding? **Y / N**

Do you form thick scars from cuts, burns or surgical procedures? **Y / N**

Do you have hyperpigmentation (darkening of skin) or hypopigmentation (lightening of skin) or marks after physical trauma? **Y / N**

Do you wear contact lenses? **Y / N**

Are you planning an event or vacation in the next 3-4 months that will expose you to the sun? **Y / N**

Do you have any metal implants (screws, plates) or a pacemaker? **Y / N**

Have you ever experienced claustrophobia? **Y / N**

Do you wear sunscreen every day? **Y / N** Just during sun exposure? **Y / N**

If Yes, what brand and SPF? ____

Do you tan in a tanning salon? **Y / N** If Yes, last date (MM/YY):___________________________

Smoking Status (Choose One)

Never smoker

Current every day smoker

Current social smoker

Cigar smoker

Former smoker (date quit) ____________________

Alcohol Intake (Choose One)

Never drinker

Less than 1 drink per day

2-3 drinks per day

3 or more drinks per day

Socially (weekends, events)

Allergies to medications and skin care products:

____

____

____

Past Medical History

Cirlce any of the following medical conditions that you currently have or had have:

Anxiety	Elevated Blood Pressure	Lymphoma
Arthritis	End Stage Renal Disease	Lung Cancer
Asthma	Epilepsy	Breast Cancer
Atrial Fibrillation	Esophageal Reflux (GERD)	Colon Cancer
Benign Prostatic Hyperplasia (BPH)	Hearing Loss	Prostate Cancer
COPD	HIV/AIDS	Radiation Treatment
Cerebrovascular Accident (CVA)	Hypercholesterolemia	Transplant
Coronary Artery Disease	Hyperthyroidism	Seizures
Depression	Hypothyroidism	Stroke
Diabetes	Hepatitis (type)__________	Other: ______________
Disease caused by COVID-19	Leukemia	

Medications

List all current medications (prescription, OTC medications and supplements) including dose and frequency:

Medication Name	Dose	Frequency

____ ________________________

Patient or Patient Representative Signature Date