Lisa Rux, Licensed Medical Aesthetician

James S. Kadi, M.D.
Plastic & Reconstructive Surgery

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Skin Care

Comprehensive Client Profile

Name: ____________________________ Date of Birth: __________ Age: _____ Sex: ☐female ☐ male
Home Address: _________________________ City_________________ State________ Zip___________
Home Phone: __________________________ Business Phone: __________________________________
Cell Phone: _____________________________ E-Mail Address: __________________________________
SS# __________________________________ Marital Status:☐ married ☐single ☐divorced ☐widowed
Pharmacy name: ________________________________ Pharmacy phone number ____________________
In case of Emergency contact: Name: ____
Emergency contact phone number: Home: _________________________ Cell: ______________________
Who may we thank for referring you to our office? ____
Who is your family physician? ____________________________phone: ____________________________
What is the reason you are consulting with Lisa Rux, Licensed Medical Aesthetician? _________________
____
Employment Type:☐ Employed Full Time ☐ Employed Part Time ☐ Not Employed ☐ Student ☐ Retired
Employer ____
Address: ________________________________City________________ State__________ Zip__________
Occupation: ____

Future Appointments/Contacts:

- May I call you at your ☐home ☐work ☐cell phone number to confirm future appointments? ☐Yes ☐No
- May I contact you via ☐mail ☐email about future promotions and news?☐Yes☐No

Medical History

1. Do you consider yourself to be in good health? ☐ YES ☐ NO
   Explain:____
2. Have you seen a physician for a medical problem within the past 12 months? This includes Emergency room and any surgeries you have had. ☐ YES ☐ NO **If YES, please list.**
   ____
   ____
3. Are you allergic to any food, drugs/ medications (over the counter and prescription)? Please describe allergic reaction to each.____
   ____
   Have you ever had a reaction to any of the following?
   ☐Cosmetics ☐Pollen ☐animals ☐fragrance ☐iodine ☐sunscreens ☐sulfites
   (**If you checked any, then please explain and describe reaction to each**.)
   ____
   ____
4. Are you taking any medication or drugs now? Please include over the counter and any homeopathic supplements. ____
   ____
5. Have you had surgery before (include cosmetic surgery)? ☐ YES ☐ NO **If YES, please list Procedure and approximate date.**____
   ____
6. Do you take aspirin on a daily basis? --☐ YES ☐ NO
7. Have you ever had an unusual reaction to a local or general anesthetic? -------------- ☐YES ☐ NO
8. Have you ever had radiation treatment? (For example, for cancer, skin rashes, etc.) ☐YES ☐NO
   When? __________________________For what? ______________________________________
9. **Social History:**
   Are you in a high risk group for HIV? ☐Yes ☐No If yes, explain.___________________________
   Do you smoke? ☐Yes ☐No If yes, how much? ________________________
   Do you drink alcohol? ☐Yes ☐No If yes, how often? ________________________

Medical History

(continued)

10. **Past Medical History:** Do you have a history of problems with any of the following?
    If so, PLEASE CIRCLE.
    HEART PROBLEMS: ……………………………………mitral valve prolapse, heart attack, high blood pressure, chest pains, heart murmur, artificial heart valve.
    LUNG PROBLEMS: ……………………………………...TB, pneumonia, emphysema, shortness of breath, asthma.
    LIVER PROBLEMS: ……………………………….……..jaundice, hepatitis.
    KIDNEY OR URINARY PROBLEMS: ………………..... kidney stones, infection.
    ENDOCRINE DISORDER: ……………………………hypo or hyperthyroidism, Addison's disease.
    DISEASE OF THE GASTROINTESTINAL TRACT: ….ulcers, diverticulitis, colitis

11. **Check ALL that apply:**

☐Weight change	☐Weight change	☐Seizures	☐Dry eyes
☐Joint/muscle pain	☐Chronic cough	☐Chronic diarrhea	☐Swollen lymph
☐Chest pain	☐Jaundice	☐Easy bleeding	☐Rapid heart beat
☐Depression	☐Easy bruising	☐Hepatitis/HIV/AIDS	☐Herpes
☐Varicose veins	☐Epilepsy	☐Hysterectomy	☐Diabetes
☐Lupus	☐Migraines	☐Heart problems	☐Any Metal Implants
☐Hormonal Imbalance	☐Frequent headaches	☐Restless leg syndrome	☐High or Low Blood Pressure

If yes to any of the above, then please explain: ____
____
____

12. Please use this space to give additional information about your Medical History that was not listed above.____
____
____

CLIENT NAME: (PRINT) ______________________________ **DATE:** __________________

Skin Questionnaire

Date: _________________ Client Name (PRINT): _____________________________________

1. What SPF sunscreen do you use on your face? _______________________
2. What SPF sunscreen do you use on your body? ______________________
3. Are you currently sunbathing and/ or using a tanning bed? ☐Yes ☐ No
   If yes, please explain:
   How often?_______________________
   Length of exposure each time? ______
   ____
4. How many ounces of plain water do you consume daily? ___________________
   ____
5. Do you experience an oily shine during the day? ☐ Yes ☐ No ☐ Occasionally
6. Do you experience skin breakouts?
   ☐ Yes ☐No ☐ Occasionally
7. Do you ever experience these conditions on your skin?
   ☐Flakiness ☐ Tightness ☐ Obvious Dryness
8. Do you consume caffeine? ☐Yes ☐No How much? __________daily __________weekly
9. Do you smoke? ☐Yes ☐No How much? ______________daily ______________weekly
10. Have you ever had a chemical or glycolic peel? ☐ Yes ☐ No **If yes, then please explain.**
    ____
11. Do you currently use and/or have used in the past?
    ☐ Retin-A ☐ Tretinoin Cream ☐Isotretinoin (Accutane)
    Please explain: ____
12. Do you have a tendency to develop redness? ☐ Yes ☐ No
13. Do you have or ever been diagnosed with Rosacea? ☐ Yes ☐ No
14. Do you wear contact lenses? ☐ Yes ☐ No
15. What level do you consider your pain threshold to be? ☐ Low ☐ Medium ☐High

Select one (1) that matches your skin type:

Skin Type	Characteristics
☐ 1	Always Burns Never Tans
☐ 2	Usually Burns Tans less than average
☐ 3	Sometimes mild burns Tans more than average
☐ 4	Rarely burns Tans more than average
☐ 5	Rarely burns Tans profusely
☐ 6	Never burns Deeply pigmented

Skin Questionnaire
(continued)

16. Do you have any special skin problems pertaining to your face? ☐ Yes ☐ No
    If yes, Specify ____
17. What temperature of water do you use to cleanse with? ☐ Hot ☐ Warm ☐ Cold
18. What daily skin care products do you presently use? **PLEASE LIST NAME OF PRODUCT.**
    ☐Cleanser __________________________ ☐Moisturizer __________________________
    ☐Toner __________________________ ☐Sunblock __________________________
    ☐Eye cream __________________________ ☐Scrubs __________________________
19. What changes would you like to see in your skin? __________________________
    ____
20. **FEMALE Clients Only**
    Are you taking oral contraceptives? ☐ Yes ☐ No
    Specify: ____
    Are you pregnant or trying to become pregnant? ☐ Yes ☐No
    Are you lactating? ☐ Yes ☐ No
    Do you still have menstrual periods? ☐Yes ☐No Date of last menstrual period______________
    Are you experiencing any menopause symptoms? ☐Yes ☐No Specify: ___________________
    Are you undergoing hormone replacement therapy? ☐ Yes ☐ No Specify: _________________
21. **Male Clients Only**
    What is your current shaving system? ☐ Electric Shave ☐ Wet Shave
    Do you experience irritation of shaving? ☐ Yes ☐ No
    Do you experience ingrown hairs? ☐ Yes ☐ No

☐ **I understand**: A digital photo will be taken prior to any treatment with Lisa Rux, Licensed Medical Aesthetician, and can be referred to at any time by Lisa Rux and yourself for comparison results.

☐ **I agree** ☐ **I disagree**: I give consent for Lisa Rux, Licensed Medical Aesthetician and the office of James Kadi, M.D. to use my before and after photos for reference to current and future patients through before and after photo albums and on the internet / website for before and after treatment photos.

I understand, have read and completed all answers truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: ____________________________________ Date: _________________

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