New Patient Intake Form

How to use this form: print it, or type into it on screen and then print it. Sign it by hand and **bring it to your appointment**. Please do not email a completed form: it contains private health information. Questions? Call us at (808) 546-9544.

JENNIFER M. LEE FNP, LLC dba JEN MEDICAL AESTHETICS

1314 S. King Street, #604

Honolulu, HI 96814

808-546-9544

Full Name

Date of birth (MM/DD/YYYY)

Street Address

Country

State

City

Postal code

Cell Phone

Phone

Email

Preferred Method of Contact (check all that apply)

☐ Cell Phone ☐ Home Phone ☐ Email

Would you like to be on our e-mail list to receive product/service specials? (choose one)

☐ Yes ☐ No

How did you hear about JenMedical Aesthetics?

Emergency Contact Name:

Relationship:

Emergency contact phone number:

WHAT CONDITIONS WOULD YOU LIKE TO IMPROVE ABOUT YOUR SKIN? CHECK ALL THAT APPLY: (check all that apply)

- ☐ Acne
- ☐ Rosacea
- ☐ Facial Scarring
- ☐ Uneven Tone/Texture
- ☐ Enlarged Pores
- ☐ Age Spots/Freckles
- ☐ Fine Lines/Wrinkles
- ☐ Sun Damage
- ☐ Dehydration

Other concerns:

Are you currently having any skin treatments? (choose one)

☐ Yes ☐ No

If yes, what type?

HEALTH HISTORY

What type of work do you do?

What is your genetic background? Example, Asia, Hispanic, Indian, French, etc.

Have you seen a dermatologist in the past year? (choose one)

☐ Yes ☐ No

If yes, please list reason for visit:

Are you currently taking medications or supplements? (choose one)

☐ Yes ☐ No

If yes, please list:

How is your general health? (check one) (check all that apply)

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

FEMALE ONLY – Are you currently: (check all that apply)

- ☐ Nursing
- ☐ Pregnant
- ☐ Planning to become pregnant
- ☐ >of Pregnancies<

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE EXPERIENCED: (check all that apply)

- ☐ Cancer (Chemo/Radiation)
- ☐ Circulatory problems
- ☐ Implantable devices
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Fainting
- ☐ Eczema
- ☐ Dizziness
- ☐ Keloid Scaring
- ☐ Skin Disease
- ☐ Skin lesions
- ☐ Psoriasis
- ☐ Cystic acne
- ☐ Seizure disorder
- ☐ Hormone imbalance
- ☐ Thyroid imbalance
- ☐ Any active infection
- ☐ Diabetes
- ☐ Lupus
- ☐ Hirsutism
- ☐ Arthritis
- ☐ Cold sores
- ☐ Herpes

Any additional health problems or medical conditions? Please list:

ALLERGIES: Please list any known allergies :

Have you ever had any allergic reactions to the following? Please check all that apply: (check all that apply)

- ☐ Aspirin
- ☐ Grapes
- ☐ Salicylates
- ☐ Fish
- ☐ Milk
- ☐ Latex
- ☐ Apples
- ☐ Iodine
- ☐ Citrus

HOMECARE:

What skincare products if any are you using at home? (check all that apply)

- ☐ Cleanser
- ☐ Toner
- ☐ Exfoliants
- ☐ Moisturizer
- ☐ SPF Sunscreen
- ☐ Rx/Specialty

PLEASE MARK IF YOU ARE PRESENTLY USING, OR HAVE EVER USED, ANY OF THE FOLLOWING: (check all that apply)

- ☐ Benzoyl Peroxide
- ☐ Vitamin A
- ☐ Retin-A
- ☐ Glycolic Acid (AHA)
- ☐ Vitamin C
- ☐ Acutane
- ☐ Lactic Acid (LHA)
- ☐ Hydrocortisone (HC)
- ☐ Tetracycline treatments within the last month
- ☐ Salicylic Acid (BHA)
- ☐ Hydroquinone (HQ)

SUN PROTECTION

Do you ever use sunscreen? (choose one)

- ☐ Yes
- ☐ No

How Often?

_____

What level of protection (SPF number?)

_____

Most recent prolonged sun exposure?

_____

PHOTOGRAPHIC CONSENT

I give consent to be photographed for the purpose of medical records. (choose one)

- ☐ Yes
- ☐ No

I give the consent to be anonymously photographed for marketing and/or publication. (choose one)

- ☐ Yes
- ☐ No

Patient Signature (sign by hand)

Date (MM/DD/YYYY)