DermaTouch RN

New Patient Information

Name: ______________________________ **Birth Date**: _____/_____/_____**Age:**______________
Address: ____ **Sex: M / F**
City: ____ **State:** _______ **Zip Code:** ___________
Home: (_____)______________ **Work:** (_____)______________ **Cell:** (_____)_______
E-mail: ____
Emergency Contact: ___________________________ **Telephone:** (_____)___________________
Allergies: ____
LMP (women): ____
How did you hear about DermaTouch RN? (please check all that apply) ;
Email_____, Web_____ (Where and key words used_______________________), Referral____ (Name of person who referred you________________________)

Please put a check mark next to the procedures about which you would like to receive more information:

___ Acne Treatment
___ Botox to Flatten and Prevent Wrinkles
___ Enhanced Skin Rejuvenation
___ Collagen Augmentation
___ Wrinkles
___ Skin Toning or Pore Size Reduction
___ Facial Redness
___ Brown Spots
___ Sun Damage
___ Broken Capillaries
___ Spider Veins/Leg Veins
___ Hair Reduction
___ Shaving bumps/ingrown hair
___ Radiesse, Juvederm, or Restylane

Please put a check mark next to a past or current medical condition:

Medical History:

___ Lupus or other auto-immune deficiency Rheumatoid Arthritis "Gold" Therapy (A)
___ Currently Pregnant (A)
___ Bleeding abnormalities (A)
___ Treatment with Accutane® in the last year (A)
___ Treatment with Tetracycline® in the last month(A)
___ Keloid or very thick scarring (A)
___ Psoriasis or Vitiligo (A)
___ Pulmonary embolism/blood clot (V)
___ Leg ulcer or Phlebitis (V)
___ Blood thinning medication (V)
___ Coumadin/anti-clotting agents (A)
___ Cystic Acne (P)
___ Botox (Location& When_____________)
___ Herpes simplex or fever blisters (A)
___ Diabetes (A)
___ Light sensitive Epilepsy (A)
___ Scars that turn white or brown (A)
___ Dark spots after pregnancy, skin injury (A)
___ HIV (A)
___ Hepatitis (A)
___ Waxing/Plucking/Electrolysis within last four weeks (HR)
___ Hirsutism (HR)
___ Transplant Anti-Rejection Drugs (HR)
___ Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A)
___ Tattoos/permanent make-up
___ Polycystic ovarian disease (PCOD)
___ Implants (Location:_______________)
___ Collagen injection (Location:__________)

Please list any medications or over the counter & herbal supplements that you are currently taking:____

Patient Signature ______________________________

Date ______________________________