Latour Skin Care Center
740 Cool Springs Blvd., Suite 205
Franklin, TN 37067

AESTHETIC PATIENT INFORMATION FORM

Name: _____ Date: _____

Email address: _____

REFERRED BY: Yellow Pages _____ Newspaper _____ Web _____ Another Client_____

1. What area/areas do you wish to have treated? _____
2. Are you currently under skin care by a physician? Y / N If yes, please explain:_____
3. List any topical medications you are using: _____

   List any oral medications you are taking: _____

   List any medications you are allergic to: _____
4. List any skin care products you are currently using (ex: Retin-A) _____
_____
5. Are you pregnant? Y / N Are you breastfeeding? Y / N
6. Have you ever had Fever Blisters in the treatment area? Y / N
7. Have you had any unusual scars? Y / N If yes, Where? _____ Explain: _____
8. List allergies (Metals, Seasonal, or Topical):_____
9. Have you ever had : Laser skin resurfacing? Y / N When? Explain: _____

   Any photosensitive disorder (lupus, porphyria, sun rash, etc.)? Y / N Explain: _____

   History of skin cancer or atypical moles? Y / N Explain: _____

   Unusual skin or systemic conditions? Y / N Explain: _____

   Previous laser or electrolysis treatments? Y / N When? Explain: _____

   Recent exposure to sun, tanning booths, or self-tanners? Y / N If so, when? _____
10. Do you have or have you had: History of hives? Y / N Hypertension? Y / N Skin Cancer/Melanoma? Y / N
11. Describe your skin by checking ALL the following conditions that apply to you:

    Acne _____ Acne Scars _____ Large Pores _____ Rosacea _____ Hyper-pigmented _____

    Freckles _____ Blotchiness _____ Melasma _____ Sallow _____ Hypo-pigmented _____

    Wrinkled _____ Dehydrated _____ Sun Damaged _____ Broken Surface Blood Vessels _____
12. Have you ever had an allergic reaction to anesthesia? Y / N

Failure to cancel your appointment within 24 hours notice will be subject to a charge of ½ the cost of treatment scheduled. **Patient (or guardian) Signature:** **Date:**