(502) 895-0040 | Toll free (800) 477-0055
FAX: (502) 400-4021 or (502) 368-5329
www.eyecenters.com

Cosmetic Intake Form

Last name _____ First name _____

Date of Birth _____ Referred by _____

Street address_____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Emergency Contact _____ Relationship _____

Phone number _____

What are your skin concerns? Please check any and all that apply.

[ ]Fine lines and wrinkles [ ]Deep lines and wrinkles [ ]Acne
[ ]Redness [ ]Brown Spots [ ] Tone/Texture

What services are you interested today?

[ ]Botox [ ]Dysport [ ]Dermal fillers
[ ]Cosmetic Surgery [ ] Skin care products

Have you ever had any of the following treatments?

[ ] Botox When was your last treatment? _____
[ ] Dysport When was your last treatment? _____
[ ] Dermal filler When was your last treatment? _____
[ ] Microdermabrasion When was your last treatment? _____
[ ] Facial Peel What kind?_____ When?
[ ] Cosmetic Surgery What kind?_____ When?_____

What skin care products are you currently using?

_____
_____

_____

_____

Have you ever had skin cancer?

[ ]Yes, when and what kind _____ [ ] No

Do you use any prescription medication for your skin? If yes, please list.

Have you ever had cold sores?

[ ] Yes, my last outbreak was _____ [ ] No

Do you have problems with scarring?

[ ] Yes [ ] No

Do you have any problems with anesthesia?

[ ] Yes [ ] No

Do you have any problems with bleeding?

[ ] Yes [ ] No

Please list the medications (prescribe and over-the-

counter that you take?_____

_____

_____

_____

Patient Signature: _____