Grandview Aesthetic Medicine
833 Grandview Ave.
Columbus, Ohio 43215
(P) 614-437-9002; (F) 614-336-8557

New Patient Information
Aesthetics Services with Kayla Decaminada MSN, APRN, FNP-C

Today's date: _____

Demographics:

Name:_____ DOB: _____

Address: _____ City/State: _____ Zip:_____

Phone #: (_____) _____-_____ Email Address: _____

Your Skin:

What are you skin care concerns? ◊ Oily ◊ Acne ◊ Acne Scars ◊ Sun Damage ◊ Brown Spots ◊ Dry
◊ Redness ◊ Sensitivity ◊ Wrinkles ◊ Laxity ◊ Dullness ◊ Large Pores

Goals:

What are your skin care goals? _____
_____

Allergies/ Sensitivities/ Intolerances:

Have you ever had a reaction to any of the following? ◊ Cosmetics ◊ Medicine ◊ Iodine ◊ Pollen ◊ Foods
◊ Hydroxy acids ◊ Animals ◊ Fragrances ◊ Sunscreen

Are you allergic to Aspirin? ◊ Yes ◊ No
Are you lactose intolerant? ◊ Yes ◊ No

Do you have any other allergies or sensitivities that is not specified above? ◊ Yes ◊ No
Please specify: _____

SKIN CARE HISTORY:

What skin products are you currently using?
◊ None ◊ AM: _____ PM: _____

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? ◊ Yes ◊ No
If so, when was your last treatment? _____

Have you ever had Botox, Dysport, Dermal Fillers, or any resurfacing treatments? ◊ Yes ◊ No
If so, when was your last treatment? _____

Do you currently use Accutane, Retin-A, or any other prescription skin products? ◊ Yes ◊ No
If so, when was your last treatment? _____

Are you currently using any products that contain the following ingredients?
◊ Glycolic acid ◊ Lactic Acid ◊ Any exfoliating scrubs ◊ Hydroxy Acid products
◊ Vitamin A derivatives (i.e., retinol) ◊ Benzoyl Peroxide ◊ Salicylic Acid

What SPF sunscreen do you normally use on your face? _____ Body? _____

Do you sunbathe or use a tanning bed? ◊ Yes ◊ No If so, how often? _____

Do you burn easily in moderate sunlight? ◊ Yes ◊ No

MEDICAL HISTORY:

(Please list all medical diagnoses/conditions you have)

Surgical History:

(Please list all surgeries you have had and the dates.)

Current Medications/Vitamins/Supplements (Please List All):

Name of Medication	Dose	Reason For Taking	Duration of Use

Female Clients:

Are you taking oral contraceptives? ◊ Yes ◊ No

Are you pregnant or trying to become pregnant? ◊ Yes ◊ No

Are you lactating? ◊ Yes ◊ No

Are you post-menopausal? ◊ Yes ◊ No

Would you like information on how to get your Botox/Dysport treatment for free? ◊ Yes ◊ No

Are you a current patient of Anne Therese Aesthetic Medicine? ◊ Yes ◊ No

HIPAA Release of Information Authorization

Consent for access to Protected Health Care Information:

I give consent to the staff of Grandview Aesthetic Medicine to communicate with person(s) listed below regarding my medical treatment. I consent to the use of my protected health care information when communicating with the person(s) below. Grandview Aesthetic Medicine may communicate in person, by telephone, mail, e-mail, fax or other means. I may withdraw this consent at any time by notifying Grandview Aesthetic Medicine in writing. any communication prior to such notice will be considered to have been authorized by me.

Signature: _____ Date: _____

Please list names of persons or family members you authorize to receive information about you:

Name: _____ Relationship: _____

Name: _____ Relationship: _____