VISIBLE RESULTS
10555 Ocean Highway, Suite C
Pawleys Island, South Carolina 29585
843-237-5593

Today's Date: _____

Name: _____ Sex: Female___Male_____
Last First Middle

Address:_____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Contact Phone Number where a message may be left: _____
Email: _____

Emergency Contact Name: _____Phone Number: _____
Whom may we thank for referring you? _____

Please circle any of the medical conditions below that apply to you:

Cancer/Chemotherapy/Radiation	Skin Disease/Skin Cancer	HIV/AIDS
Anemia	Heart Disease	Scleroderma
Diabetes	Seizure Disorder	Hepatitis
Arthritis	Glaucoma	Acne
Cold Sores/Fever Blisters	Thyroid Imbalance	Rheumatoid Arthritis
Blood Clotting Abnormalities	Hormone Imbalance	High Blood Pressure
Multiple Sclerosis	Lupus	

Have you had a family history of skin disorders? Yes _____ No _____ Type _____

Allergies:

_____ No Known Allergies
_____ Allergies and Reactions to medications, foods, latex, cosmetic ingredients, other. Please List:

_____

Current Medications:

_____

_____

Past Surgeries or Hospitalizations: Please list with Date:

_____

_____

Past Aesthetic/Medical Cosmetic Procedures and Dates:

_____

_____

Please check the following medications and supplements that you are currently using:

___Retin-A
___Steroids
___Hydroquinone
___Glycolic Acid
___Salicylic Acid
___Lactic Acid
___Antibiotic: (which one?)_____

___ St. John's Wart
___Blood Thinners (Coumadin, Aspirin)
___ Flax Seed Oil
___Omega 3's/Fish Oil

___ Vitamin E
___Vitamin C
___Advil/Ibuprophen
___Birth Control Pills/Hormone Replacement
___Accutane

Are you pregnant, nursing, or planning a pregnancy? Yes/No

Have you taken Accutane or blood thinners in the last 12 months? Yes/No

Do you form thick or raised scars from cuts or burns? Yes/No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes/No _____ Describe: _____

Have you had any facial hair removal in the last 6 weeks? (circle all that apply): Shaving,Tweezing, Waxing,Depilatories Shaving/Tweezing/Waxing/Depilatories

Do you have a low pain tolerance? Yes/No

Do you have a social event in the next 2 weeks? Yes/No

Aesthetic Products, Treatments, and Procedures

Please let us know which of the following aesthetic products, treatments, and procedures interest you. Please check all that apply:

____ Sun Damage/Brown Spots/Freckles
____ Brow Shaping/Waxing
____ Brow/Lash Tinting
____ Lash Lengthening and Fullness
____ Skin Rejuvenation
____ Chemical Peels (Lactic, Glycolic Salicylic)
____ Pore Size
____ Acne Treatment and Products
____ Acne Scarring
____ Professional Skincare Products
____ Permanent Cosmetics (Eyeliner, Eye Brows, Lips)
____ Dermal Fillers (Juvederm, Radiesse, Belotero)
____ Other (please specify):

____ Pigment Correction, Sun Damage
____ Skin Tightening
____ Leg Vein Correction
____ Dermaplaning
____ Laser Treatments
____ Neuromodulators (Botox, Xeomin)
____ Hair Removal
____ Facial Vein Correction
____ Facial Redness/Broken Capillaries
____ Stretch Marks
____ Skin Needling (Dermatude)
____ Topical Wrinkle Cream

_____

_____

_____

Patient Signature Date

_____

Signature of Person Responsible Date