FRANCEL AESTHETICS

314-251-6845

PATIENT INFORMATION

Name _____ Birth Date _____ Age _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
E-Mail _____ Family Physician _____ Referred by _____

MEDICAL INFORMATION

Do You Have Any of The Following? __Acne __Skin cancer __Pre-cancerous lesions
__Rosacea __Cold sores __Any skin irritations __Diabetes __High blood pressure

Do you Smoke? _____ How much? _____ Use to? ___ Live with a smoker? _____

Please list all vitamins (if any) taken daily. _____
Please list all current medications and purpose.
_____ Reason _____
_____ Reason _____
_____ Reason _____

Do you have any of the following allergies? (Please check the appropriate line)

___ Aspirin ___Lactose intolerance ___Any Sulfur reactions Other _____
(Sulfur is contained in many acne medications)

Do you wear contacts? __ yes __ no
Are you pregnant? __ yes __ no Is your menstrual cycle regular? __ yes __no
Are you menopausal? __ yes __ no If so, list any symptoms _____
Has your skin changed since starting menopause? _____
Are you on hormone therapy? _____ What type? _____

PERSONAL INFORMATION

Occupation _____ Married _____ Single _____ Divorced _____ Widowed _____
Number of Children _____ Ages _____
How many hours of sleep do you average per night? _____

DIET INFORMATION

Please explain your typical daily diet _____
How often do you eat out? _____ Daily soda intake? _____ Daily water consumption? _____

SKIN CARE

What skin treatments have you had in the past?

Facials _____ How often ? _____ Microdermabrasions _____ How often? _____
Facial Peels _____ How often? _____ What type? _____
Laser Treatments _____ How often ? _____ What type? _____
Any other treatments? (i.e. Botox, fillers) _____
Any cosmetic and/or reconstructive surgery ? _____
List any other surgeries _____
_____

How would you like to improve your skin? _____

_____

_____

Are you on the medication **Acutane?** _____, or have you ever been ? _____
If so, how long have you been off of Accutane? _____

Are you currently using **Retin-A**? _____ What type? _____ If you have used Retin-A in the past, how long ago was that? _____ What type were you on? _____ What did you think of the results? _____.

Are you exposed to the sun? _____ How often? _____ How long at a time? _____
Do you use a sunscreen? _____ What kind? _____
Do you ever use a tanning bed? _____ How often? _____

*What skin care products do you use in the **morning** & in which order?

_____
_____
_____
_____

*What skin care products do you use in the **evening** & in which order?

_____
_____
_____
_____

GENERAL INFORMATION

What's your ethnicity_____ Eye color_____Hair color _____
Skin color_____

*Please check your type of skin (Fitzpatrick Classification)

_____	**TYPE I**	Very, very sensitive	Always burns in the sun
_____	**TYPE II**	Very sensitive	Usually burns in the sun
_____	**TYPE III**	Sensitive	Sometimes burns in the sun
_____	**TYPE IV**	Moderately sensitive	Rarely burns in the sun
_____	**TYPE V**	Minimally sensitive	Very rarely burns in the sun
_____	**TYPE VI**	Least sensitive	Never burns in the sun

Would you like to receive in-office skin care treatments? _____
How much time do you have for treatments? ____Once every 2 weeks ____Once a month
____Once every 2 months ____2-3 times a year

How much time are you willing to spend at home caring for your skin? _____
AM 2-min.____ 5-min.____ 10-min.____ More____ **PM** 2-min.____ 5-min.____ 10-min.____ More____

Do you want to read information on skin care products? _____ If you had confidence that your skin could improve, are you willing to spend the time and resources to achieve this goal?_____

OUR COMMITMENT TO YOU

We will always be honest with our recommendations for your skin care. You will not be pressured into purchasing products or procedures that you do not want. Remember: Beautiful skin starts with a healthy lifestyle. We can help you achieve both.

Please sign _____ Date _____