Lamb Medical PC

Concierge Family Medicine & Aesthetics

AESTHETIC PATIENT INTAKE FORM

NAME:_____ **DOB:**_____ **AGE:**_____

GENDER: MALE ❑ FEMALE ❑ OTHER ❑ HEIGHT:_____ **WEIGHT:**_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

MOBILE: (_____) _____ - _____ HOME: (_____) _____ - _____

DO WE HAVE YOUR CONSENT TO CALL YOU AND LEAVE A MESSAGE? YES ❑ NO ❑

IF YES, ON WHAT NUMBER: (CHECK ALL THAT APPLY.) CELL ❑ HOME ❑

DO WE HAVE YOUR CONSENT TO TEXT YOU APPOINTMENT REMINDERS? YES ❑ NO ❑

EMAIL ADDRESS:_____

MAY WE EMAIL YOU PROMOTIONS AND/OR SPECIALS: YES ❑ NO ❑

HOW DID YOU HEAR ABOUT LAMB MEDICAL? SOCIAL MEDIA ❑ INTERNET ❑

FRIEND ❑ WORD OF MOUTH ❑ REFERRAL_____

OCCUPATION:_____

EMPLOYER:_____

EMERGENCY CONTACT NAME:_____

RELATIONSHIP TO PATIENT:_____

CONTACT NUMBER:_____

PRIMARY REASON FOR YOUR VISIT:_____

_____

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ALLERGIES TO MEDICATIONS, FOOD, LATEX OR TOPICAL SOLUTIONS (INCLUDING PIGMENT/DYES) YES ❑ NO ❑

IF YES, PLEASE LIST_____

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN, DERMATOLOGIST, OR OTHER HEALTH CARE PROFESSIONAL IN THE PAST YEAR? YES ❑ NO ❑

IF YES, PLEASE EXPLAIN:_____

PLEASE LIST ANY PRESCRIPTION MEDICATIONS YOU TAKE:

_____

PLEASE LIST ANY OVER THE COUNTER MEDICATIONS YOU TAKE (INCLUDING VITAMINS,SUPPLEMENTS, ASPIRIN, ETC):

_____

SOCIAL HISTORY

DO YOU SMOKE? YES ❑ NO ❑ IF YES, HOW MUCH/ HOW OFTEN/ HOW LONG?_____

ALCOHOL USE? YES ❑ NO ❑ IF YES, HOW OFTEN?_____

RECREATIONAL DRUG USE? YES ❑ NO ❑

CAFFEINE USE, HOW MANY CUPS OF COFFEE A DAY?_____

DO YOU EXERCISE? IF SO, WHAT TYPE OF EXERCISE/ HOW OFTEN?_____

SURGICAL HISTORY

PLEASE LIST ANY SURGERIES OR MAJOR HOSPITALIZATIONS/YEAR (PLEASE

INCLUDE PLASTIC SURGERY). _____

FEMALE PATIENT ONLY

ARE YOU USING A PRESCRIBED CONTRACEPTIVE (PILL, NUVARING, IUD)?YES ❑NO ❑

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ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? YES ❑ NO ❑

ARE YOU CURRENTLY BREASTFEEDING? YES ❑ NO ❑

WHAT ARE YOUR CONCERNS WITH YOUR SKIN/APPEARANCE? PLEASE CHECK ALL THAT APPLY:

❑ FOREHEAD LINES	❑ THINNING OR INADEQUATE LASHES
❑ FROWN LINES	❑ UNDERARM SWEAT OR ODER
❑ CROW'S FEET	❑ REDNESS OR ROSACEA
❑ FLATTENED/SUNKEN CHEEKS	❑ FRECKLES & PIGMENTATION (BROWN SPOTS)
❑ LINES/WRINKLES AROUND MOUTH & NOSE	❑ FACIAL HAIR OR EXCESSIVE BODY HAIR
❑ LIP APPEARANCE/TEXTURE	❑ ACNE OR ACNE SCARRING
❑ THIN LIPS	❑ DOUBLE CHIN
❑ TEXTURE, FIRMNESS AND SKIN QUALITY OF NECK, CHEST OR OTHER AREA ON THE BODY	❑ LOSS OF SKIN VIBRANCY

SKIN TYPE

❑ TYPE I- ALWAYS BURNS, NEVER TANS
❑ TYPE II- ALWAYS BURNS, SOMETIMES TANS
❑ TYPE III- SOMETIMES BURNS, ALWAYS TANS
❑ TYPE IV- RARELY BURNS, ALWAYS TANS
❑ TYPE V/VI BROWN, MODERATELY PIGMENTED SKIN

WHAT IS YOUR ETHNIC BACKGROUND:_____

NATURAL HAIR COLOR:_____

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ARE YOU CURRENTLY USING ANY SKINCARE PRODUCTS THAT CONTAIN ACTIVE INGREDIENTS (GLYCOLIC,SALICYLIC ACID, RETIN-A, TRETINOIN OR ANY OF ITS DERIVATIVES)?_____

WHAT SKIN PRODUCTS ARE YOU CURRENTLY USING? PLEASE LIST BRANDS WHERE KNOWN.

CLEANSER:_____

TONER:_____

MOISTURIZER:_____

EYE PRODUCTS:_____

RETIN-A/ TRETINOIN:_____

OTHER (SCRUBS, EXFOLIANTS, BODY LOTIONS, ETC)_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

FACIAL	**YES ❑ NO ❑**
CHEMICAL PEEL	**YES ❑ NO ❑**
MICRODERMABRASION	**YES ❑ NO ❑**
LASER TREATMENT	**YES ❑ NO ❑**
MICRONEEDLING	**YES ❑ NO ❑**
BOTOX/DYSPORT/XEOMIN	**YES ❑ NO ❑**
IF YES, WHEN WAS YOUR LAST TREATMENT, ANY PROBLEMS? _____	
FACIAL FILLERS	**YES ❑ NO ❑**
IF YES, WHEN WAS YOUR LAST TREATMENT, ANY PROBLEMS? _____	

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MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU ARE AFFECTED BY:

❑ ACNE	❑ KIDNEY DISEASE
❑ ACCUTANE IN THE PAST 6 MONTHS	❑ LUNG DISEASE
❑ ANXIETY, DEPRESSION	❑ LUPUS
❑ ANY CURRENT ACTIVE INFECTION	❑ MELASMA
❑ ARTHRITIS	❑ MIGRAINES
❑ ASTHMA	❑ MYOCARDIAL INFARCTION/PACEMAKER
❑ BLEEDING DISORDERS	❑ MYASTHENIA GRAVIS/ALS
❑ BOWEL DISEASE	❑ NAIL FUNGUS
❑ CANCER	❑ PERMANENT MAKEUP
❑ COLD SORES/FEVER BLISTERS	❑ POLYCYSTIC OVARY DISEASE
❑ DIABETES	❑ PSORIASIS
❑ DRY EYES	❑ ROSACEA
❑ EXCESSIVE SWEATING/HYPERHIDROSIS	❑ SEIZURE DISORDER/EPILEPSY
❑ FAINTING	❑ SKIN CANCER
❑ HEART DISEASE	❑ STROKE OR TIA (MINI-STROKES)
❑ HEPATITIS	❑ THYROID DISEASE
❑ HIGH BLOOD PRESSURE	❑ URINARY DISEASE
❑ HIV/AIDS	❑ VITILIGO
❑ KELOID SCARS	❑ WARTS

Patient Signature:_____ **Date:** _____

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Photography and Social Media Informed Consent Form

- I hereby authorize Dr. Mary Lamb and her associates or licensees the right to use my photographs, video and/or testimonials taken that showcase me and/or the procedure that I am having performed to include but not limited to Instagram, Facebook, and other social medical platforms and for professional medical purposes, including but not limited to, showing these images on electronic digital networks for purposes of medical education, patient education, lay publication, advertising and marketing or during lectures to medical or lay groups.
- I hereby certify that I am over 18 years old and that it is my intention to be legally bound by this agreement. I understand that the photograph and/or videos taken may contain recognizable images of my face and/or body.
- I understand that all information will be kept confidential and will be reported in an anonymous fashion. I will not be described by name in any publication.
- The information, photographs, videos and/or testimonials disclosed under consent, or some portion thereof, are protected by state law and/or the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any use or disclosure of such information, photographs, videos and/or testimonials carries with it the potential for an unauthorized redisclosure.
- I release Dr. Mary Lamb, the practice and its agents and employees, from all liability in connection with any such redisclosure and/or disclosure and/or use of information, photographs, videos and/or testimonials by individuals and/or entities other than Dr. Mary Lamb, the practice and its agents and employees.
- I release Dr. Mary Lamb, the practice and its agents and employees, from all liability in connection with information, photographs, videos and/or testimonials of me authorized pursuant to this release and consent. I waive any right to inspect or approve the information, photographs, videos and/or testimonials prior to use.
- I release Dr. Mary Lamb, the practice and its agents and employees, from any claim I may have relating to use of the information, photographs, videos and/or testimonials, including any claim for payment in connection with the use of them.
- I understand that I may revoke this consent at any time by providing a written request. If I do so revoke this consent, it will have no effect on any use or disclosure of photographs, videos or testimonials prior to revocation date.
- I may refuse to sign this Release and Consent without such refusal affecting the medical treatment I receive with Dr. Mary Lamb and/or her employees.

PATIENT SIGNATURE:_____ **DATE**_____