KORU
Wellness Aesthetics NYC

PATIENT INFORMATION & MEDICAL HISTORY

Welcome! In order to provide you with the most appropriate treatments, please complete the following (very thorough) questionnaire. There are four (4) pages total. All information is strictly confidential. Please ask for clarification at any time if needed.

**By providing your email address below, you agree to be added to our mailing list for marketing purposes and to communicate with you about your health unless otherwise indicated.*

PERSONAL INFORMATION

○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Other: _____ Patient Name: _____

Today's Date: _____ Email*: _____

Date of Birth: _____ Age: _____ Occupation: _____

Home Address/City/State/ZIP: _____

Home Phone: (_____)_____ Cell Phone: (_____) _____

Emergency Contact Name/Phone: _____ Relationship to Patient: _____

How were you referred to us? _____

MEDICAL & SURGICAL HISTORY

Are you under the care of another aesthetic practitioner, dermatologist, or plastic surgeon? ○ Yes ○ No

If yes, for what: _____

Name of Practitioner: _____ Practitioner's Phone Number: _____

For our female patients:

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

Are you lactating/breastfeeding? ○ Yes ○ No

Are you using contraception? ○ Yes ○ No

Do you have, or have you ever had (or been suspected of having), any of the following medical conditions? *If yes, please explain and include treatment, if any.*

○ Alcoholic/Non-alcoholic liver disease

○ Amyotrophic Lateral Sclerosis (ALS)

○ Any disease requiring anticoagulation therapy (E.g. warfarin for blood clots): _____

○ Any acute/active/chronic infection: _____

_____

○ Arthritis

○ Autoimmune disease: _____

○ Blood clotting/Platelet abnormalities: _____

○ Blood disorders: _____

○ Cancer: _____

○ Chronic liver disease/Hepatitis

○ Contact lenses

○ Heart disease/Pacemaker

○ Dermatological (skin) diseases or lesions: _____

○ Diabetes

○ Skin/facial cancer: _____

○ Herpes/Cold Sores/Fever Blisters

○ HIV/AIDS

○ Hormone/thyroid imbalance

○ Inflammation, irritation or infection of the skin: _____

○ Keloid formation/scarring

○ Neurological Disorders (e.g. Lambert-Eaton Syndrome, Multiple Sclerosis, ALS, Myasthenia Gravis: _____

○ ***None of the above***

- Please explain any of the above and list any other health problems or medical conditions:
  _____

- Please list any previous hospitalizations/surgeries: _____
  _____

- Have you had plastic surgery or other surgical procedures on your face/neck areas? ○ Yes ○ No
  If yes, where and when? _____

ALLERGIES

- Have you ever had a reaction – allergic, sensitivity, or otherwise, to any of the following?

(Please check all that apply and describe the reaction.)

○ ***No known drug or other allergies***

○ Aspirin: _____

○ Foods (including Beef / Dairy / Apples / Citrus / Cow's Milk / Grapes / Aloe Vera / Mushrooms):
_____

○ Hydroquinone or skin bleaching agents

○ Hypersensitivity to medications/Multiple severe allergies: _____

○ Latex: _____

○ Lidocaine: _____

○ Perfumes/preservatives/dyes: _____

- Please list any other allergies or allergic reactions (include any to skincare products): _____
  _____

MEDICATIONS

- What **oral** (by mouth) medications are you presently taking (within 14 days)? ○ ***None***

○ Aspirin: _____

○ Anti-inflammatories (e.g. Naproxen, NSAIDs):
_____

○ Antibiotics: _____

○ Birth control pills/other hormones: _____

○ Any kinds of blood thinners: _____

○ Fish Oil Supplements/Garlic Supplement/St. John's Wort/Vitamin E Supplements

○ Mood altering/anti-depression medications: ___

○Others (Please list): _____

- What **topical** medications or creams/ointments have you ever used or are currently using? ○ ***None***
  - ○ Alpha Hydroxy Acids (e.g. glycolic acid, lactic acid, malic acid, citric acid, tartaric acid, etc.)
  - ○ Beta Hydroxy Acids (e.g. salicylic acid)
  - ○ Retin-A®/Tretinoin®/Differin®/Renova®/Avage®/EpiDuo®/Ziana®
    If yes, which one? For how long? What strength? _____
  - ○ Accutane® (Isotretinoin) Last use: _____
  - ○ Topical steroids: _____
  - ○ Others (please list): _____

LIFESTYLE

Please rate your level of stress *(1= low, 10= high):* ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Do you regularly salt your food? ○ Yes ○ No

Do you exercise? ○ Yes ○ No

Are you post-menopause? ○ Yes ○ No

What is your daily intake of caffeine? _____

How much sleep do you get a night? _____

How much water do you drink a day? _____

How many alcoholic drinks do you drink a week on average? _____

Are you a vegetarian or vegan or have other dietary specifications? ○ Yes ○ No

Do you/did you smoke or use tobacco? ○ Yes ○ No

If yes, how many packs a day? _____ When did you stop smoking? _____

AESTHETIC HISTORY

Please describe your skin *(Please check all that apply):*

○ Normal
○ Dry
○ Oily
○ T-Zone/Combination
○ Acne (where?_____)
○ Mature
○ Dehydrated/Lacking moisture
○ Asphyxiated (clogged)
○ Thick
○ Thin
○ Saggy/Has laxity
○ Wrinkled
○ Dull
○ Large pores
○ Comedones
○ Blackheads
○ Rosacea
○ Eczema
○ Psoriasis
○ Sun-damaged
○ Melasma
○ Hyperpigmentation
○ Uneven/Blotchy
○ Milia
○ Cysts
○ Acne-scarred
○ Sallow
○ Telangiectasias
○ Broken surface capillaries
○ Under eye circles
○ Puffy eyes
○ Extra chin fat

Please describe your **skincare routine**, including brands if possible:

○ Makeup Remover: _____
○ Cleanser: _____
○ Toner: _____
○ Serum: _____
○ Eye Cream: _____
○ Moisturizer (Day)/SPF: _____
○ Moisturizer (Night): _____
○ Exfoliant: _____
○ Masque(s): _____
○ Lip Treatment: _____
○ Targeted Treatments: _____
○ Other: _____

- Do you consider your skin *(check the best option):* ○ Sensitive ○ Resilient ○ Unsure

- What is your **hereditary background**? *(Please list all – this is to help determine how your skin may react to laser and other treatments):* _____

*If considering **neuromodulator/filler treatment**, please answer/explain:*

- Have you had any neuromodulator (Botox® /Xeomin®/Dysport®) procedures before? ○ Yes ○ No
- If yes, which neuromodulator was used, where, when/last treatment, and were you satisfied with the results? _____

- Have you had any **dermal filler** procedures before? ○ Yes ○ No
- If yes, what filler was used, where, when/last treatment, and were you satisfied with the results? _____

*If considering **laser/light services**, please answer/explain:*

- What was/is your natural hair color as a young adult?
  ○ Blond ○ Red/Auburn ○ Light Brown ○ Dark Brown ○ Black ○ Gray
- What is your natural eye color? ○ Blue ○ Green ○ Hazel ○ Brown ○ Black

- Which of the following best describes your skin's reaction to sunlight?
  - I. Always burns, never tans
  - II. Usually burns, sometimes tans with difficulty
  - III. Sometimes burns, slowly tans
  - IV. Rarely burns, tans easily
  - V. Rarely burns, tans quickly and easily
  - VI. Never burns, always tans easily and deeply
- Have you ever had laser hair removal? ○ Yes ○ No
  - If yes, please describe what area/when: _____
- Have you used any of the following hair removal methods in the past six weeks?
  ○ Shaving ○ Waxing ○ Electrolysis ○ Pluck ○ Tweezing ○ Stringing/Threading ○ Depilatories
  - If yes, what area? _____
- Have you recently had laser resurfacing? ○ Yes ○ No
- How much sun exposure do you get on average? _____
- Do you currently have a sunburned/windburned/chapped/red face? ○ Yes ○ No
- Do you regularly use tanning salons or sun bathe? ○ Yes ○ No
  - If yes, how often? _____
- Have you had any recent (within the last 2-3 weeks) tanning or sun exposure that changed the color of your skin? ○ Yes ○ No
- Have you recently used any self-tanning lotions or treatments? ○ 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
  - If yes, please describe: _____

History of any other cosmetic procedures: _____

_____

What are your reasons for seeking a consultation/treatment? What do you hope to achieve from this consultation? What are your **goals** for your future skin care program? _____

_____

_____

_____

Thanks for getting this far!

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Signature:_____ Date:_____