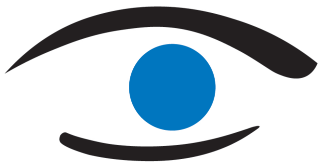

TARBORO EYE ASSOCIATES

Your Vision, Our Focus

Aesthetic Patient History Form

2807 N. Main St. Tarboro, NC 27886

Name: ______________________ Gender: ❍ Male ❍ Female

Date of Birth: ____________ Phone Number: ____________ Family Doctor: ____________

Address: ______________________

Email: ______________________

Emergency Contact Name and Number: ______________________

Do you have ANY current chronic medical illnesses we should know about? ❍ Yes ❍ No

If yes, please list: ______________________

Do you take/use ANY medications, herbal or natural supplements or topicals on a regular daily basis? ❍ Yes ❍ No

If yes, please list: ______________________

Do you have a history of cold sores, shingles, etc in the area to be treated? ❍ Yes ❍ No

Have you taken Accutane or anticoagulants in the last year? ❍ Yes ❍ No

If yes, please list the date last taken: ______________________

Do you have any permanent make-up, implants or tattoos? ❍ Yes ❍ No

If yes, please list locations: ______________________

Have you had any unprotected sun exposure, used tanning creams or tanning bed in the last 4-6 weeks? ❍ Yes ❍ No

What is the primary concern that brought you into our office? ______________________

Our goal is to respond to all our patients' needs and to provide the highest quality care. In order to provide the information and services you desire on the health and appearance of your skin; we ask you to please share any other concerns you may have by completing the section below:

Please check all that apply:

- ❍ Lines around the eyes
- ❍ Lines between eyes (angry look)
- ❍ Lines on forehead
- ❍ Puffy eyes
- ❍ Thin lips
- ❍ Dry Skin
- ❍ Oily Skin
- ❍ Looking tired
- ❍ Crease-nose to corner of mouth
- ❍ Short fragile eyelashes
- ❍ Frown or down turned mouth (sad look)
- ❍ Brown spots on face or body
- ❍ Red, blotchy skin
- ❍ Excess skin above eyes
- ❍ Thin face/no cheeks
- ❍ Crepey skin
- ❍ Sunken-in eyes
- ❍ Brown spots
- ❍ Unwanted body fat
- ❍ Aging hands
- ❍ Wrinkled neck
- ❍ Adult acne
- ❍ Broken blood vessels on face
- ❍ Spider veins on leg

Please provide some information about your current skin regimen.

Please fill out all that apply, including the name of the product(s) you use.

Cleanser: ______________________________

Toner: ______________________________

Moisturizer: ______________________________

Sunscreen/Sunblock: ______________________________

Treatments: (Retin A, Vitamin C +E, Bleaching Cream, etc.) ______________________________

____

Patient Signature: ______________________________