TARBORO EYE ASSOCIATES & AESTHETICS

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: _____