HEALTHY COMPLEXIONS SPA
by Western New York Dermatology

INTAKE FORM

Date of Birth _____

First Name _____ **Last Name** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Email** _____

Whom can we thank for referring you? _____

Skin History

When was your last skin check? _____

Have you previously had any of the following?

- ◯ Laser procedures
- ◯ Chemical peels
- ◯ Thread lift
- ◯ Facial surgery
- ◯ Hydrafacial
- ◯ Skin cancer
- ◯ Filler
- ◯ Botox/Dysport/Xeomin
- ◯ Precancerous lesions

What skincare products do you use?

◯ Soap ◯ Cleanser ◯ Toner ◯ Moisturizer ◯ Serum ◯ Scrub ◯ Mask ◯ Sunscreen

What is your skintype? ◯ Dry ◯ Normal ◯ Oily ◯ Combination ◯ Sensitive

Are you or have you been on any of the following?

	Yes	No	If yes, When?
Isotretinoin (Accutane)	☐	☐	_____
Oral antibiotics	☐	☐	_____
Topical antibiotics	☐	☐	_____
Topical sterioids	☐	☐	_____
Tazorac	☐	☐	_____
Tretinoin/Retinol, Retin-A, Differin, etc	☐	☐	_____
Finacea	☐	☐	_____
Hydroquinone	☐	☐	_____
Benzoyl peroxide	☐	☐	_____
Glycolic/salicylic asids	☐	☐	_____
Blood thinners	☐	☐	_____
Other current prescriptions or topicals	☐	☐	_____

We treat your skin.
You treat yourself.

297 Spindrift Drive
Williamsville, NY 14221
716.300.1444

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Have you had or do you have any of the following conditions:

- ☐ Acne
- ☐ Acne scars/scarring
- ☐ Itchy/flakey/scaly scalp
- ☐ Cardiac problems
- ☐ Fever blisters
- ☐ Immune disorder
- ☐ Kidney/urinary tract problems
- ☐ Rosacea
- ☐ Unwanted hair
- ☐ Sun damaged skin
- ☐ Metal pins/plates
- ☐ Herpes
- ☐ Diabetes
- ☐ Eczema
- ☐ Hair loss
- ☐ Unwanted fat
- ☐ Pacemaker
- ☐ HIV+
- ☐ Keloids
- ☐ Psoriasis
- ☐ Cellulite
- ☐ Skin laxity
- ☐ Epilepsy
- ☐ Hepatitis

List any topical/oral allergies _____

_____

List all concerns that you would like to improve and treatments that you may be interested in

_____

_____

I agree to receive appointment confirmations and promotions via text and email

◯ **Text** ◯ **Email** ◯ **Both** ◯ **Neither**

For women only

	Yes	No
Are you pregnant or breast feeding?	◯	◯
Are you trying to become pregnant?	◯	◯
If you have been pregnant, have you had hyperpigmentation or "pregnancy mask"?	◯	◯

Signature _____ **Date** _____

Photo release permission

I grant WNY Dermatology and Healthy Complexions Spa, its representatives and employees, the right to take photographs of me and my property. I authorize WNY Dermatology/Healthy Complexions Spa, its assigns and transferees to copyright, use and publish the same in print and/or electronically.
I agree that WNY Dermatology/Heatlhy Complexions Spa may use photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

I have read and understand the above:

Signature _____

Spa representative _____

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