

Lisa Rux, Licensed Medical Aesthetician
1206 Bent Oaks Court, Suite #200
Denton, TX 76210
(940) 231-5636

Consultation Form

Today's Date: _____

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Email: _____

Contact **name** in case of an emergency: _____

Emergency contact **Cell:** _____ **Home:** _____

Whom may we thank for referring you to our office? _____

What is the reason you are consulting with Lisa Rux, Licensed Medical Aesthetician?

Employer: _____

Occupation: _____

May I call you at your home cell phone to confirm future appointments?

Yes No

May I contact you via email about your future promotions? Yes No

Skin Care Questionnaire

What SPF Sunscreen (**including brand name**) do you use on your face?

Do you use it every day? Yes No

Are you currently sunbathing and / or using a tanning bed? Yes No

Check the one that best matches your skin type:

- | | |
|---|--|
| <input type="checkbox"/> Always burns / never tans | <input type="checkbox"/> Rarely burns / tans |
| <input type="checkbox"/> usually burns / tans less than average | <input type="checkbox"/> Never burns |
| <input type="checkbox"/> Sometimes burns / tans more than average | |

How much plain water do you consume daily? _____

Do you experience an oily shine during the day? Yes No

Do you experience skin breakouts? Yes No

Where are the breakouts usually on your face?

Do you experience these conditions on your skin? (check all that apply)

- | | | |
|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Flakiness | <input type="checkbox"/> Tightness | <input type="checkbox"/> Obvious Dryness |
|------------------------------------|------------------------------------|--|

Do you consume caffeine? Yes No How much daily? _____

Do you smoke? Yes No How much? _____ Daily _____ Weekly

Do you vape? Yes No How much? _____ Daily _____ Weekly

Do you **currently** use any of the following?

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Retinol | <input type="checkbox"/> Tretinoin Cream | <input type="checkbox"/> Isotretinoin (Accutane) |
|----------------------------------|--|--|

Do you have a tendency to develop redness? Yes No

Do you have or have been diagnosed with Rosacea? Yes No

What temperature of water do you use to cleanse with?

Hot Warm Cold

SKIN CARE PRODUCTS

Product	Brand	Product Skin Type
Cleanser		<input type="checkbox"/> Normal <input type="checkbox"/> Dry <input type="checkbox"/> Oily <input type="checkbox"/> Combination <input type="checkbox"/> Sensitive <input type="checkbox"/> Unsure
Toner		
Moisturizer		
Eye Cream		
Scrubs		
Topical Serums		

What changes would you like to see in your skin?

Medical History

Have you been diagnosed with Autoimmune Disease? Yes No

Please explain:

Have you seen a physician for a medical problem within the past 12 months?

Yes No

Please explain:

Are you allergic to any food, drugs, medications (over the counter or prescription)?

Yes No

Please list:

Have you ever had a reaction to any of the following? (check all that apply)

- Cosmetics Pollen Animals Latex gloves
 Fragrance Sunscreen Sulfites

Please explain:

PRESCRIPTION DRUGS

Medication	Dosage (mg)	Reason for Use

Please list all **VITAMIN SUPPLEMENTS** you are currently taking.

Are you on **BIRTH CONTROL**? Yes No

If so, which one? _____

Are you on hormone pellet or injection? Yes No

Do you take Aspirin / Ibuprofen on a daily basis? Yes No

Informed Consent

I understand, have read and completed all answers truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and / or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and / or skin professional from liability and assume full responsibility thereof. All treatments are non-refundable.

Please initial and sign below

_____ I am aware that if I cancel or no show within 24 hours of my appointment that I will be charged a fee of \$75.00. (This excludes sickness or emergencies)

Printed Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____



LISA RUX

Medical Aesthetician

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