LUXE Medical Aesthetics
21770 Kingsland Blvd. Katy, TX 77450
833-998-5893

Patient Profile and Health History

Patient Name:_____ Date:_____
Date of Birth:_____ Age:_____ Gender (please circle): M F Non-binary
Address:_____ City:_____ State:_____ Zip Code:_____
Cell Phone:_____ Home Phone: _____
Email Address:_____
Emergency Contact Name and Phone:_____
How did you hear about us?:_____ Referral Name:_____

Interest

Please indicate which of the following concerns you have about your skin:

- ☐ Age Management
- ☐ Acne
- ☐ Redness
- ☐ Scarring
- ☐ Sun damage
- ☐ Enlarged Pores
- ☐ Wrinkles/ Fine Lines
- ☐ Lose of Volume
- ☐ Skin Texture
- ☐ Stretch Marks
- ☐ Hyperpigmentation/ Melasma
- ☐ Hair Loss
- ☐ Oily Skin
- ☐ Dry Skin
- ☐ Sensitive Skin
- ☐ Skin Care Regimen Recommendations

Medical History

Do you have any of the following medical conditions (please circle those that apply):

Skin Conditions (Psoriasis, Eczema, Scars, etc.): No Yes (If YES, explain)_____
Heart Disease (Heart Attack, Palpitations, etc.): No Yes (If YES, explain)_____
Neurological Disease (Seizures, Epilepsy, etc.): No Yes (If YES, explain)_____
Lung Disease (COPD, Asthma, etc.); No Yes (If YES, explain)_____
Liver/ Kidney Disease (Cirrhosis, Hepatitis, etc.): No Yes (If YES, explain)_____
Cancer (Leukemia, Lymphoma, Melanoma, etc.): No Yes (If YES, explain)_____
Digestive Problems (IBS, Diarrhea, etc.): No Yes (If YES, explain)_____
Trauma (Injuries, Burns, etc.): No Yes (If YES, explain)_____
Infectious Disease (Cold Sores, STDs etc.): No Yes (If YES, explain)_____
Immunosuppression (HIV, AIDS, etc.): No Yes (If YES, explain)_____
Endocrine Disorder (Thyroid, Diabetes, etc.): No Yes (If YES, explain)_____
Mental Illness (Depression, Bipolar, etc.): No Yes (If YES, explain)_____
Any OTHER medical problems: No Yes (If YES, explain)_____

Please list all prescription medications you are currently taking:_____
_____
Please list all OTC medications and supplements you are currently taking:_____
_____
Have you been on antibiotics in the last 2 weeks? Yes No
Have you had any recent dental work? Yes No
Do you have any skin allergies? Yes No

LUXE | MEDICAL AESTHETICS

Medical History Continued

In the last year have you received the following treatments?

Botox Yes No Areas treated/ last treatment_____

Fillers Yes No Areas treated/ last treatment_____

Facials/Peels Yes No Please explain_____

Laser Yes No Areas treated/ last treatment_____

Microneedling Yes No Areas treated/ last treatment_____

In the last 2 years have you had any surgical procedures? No Yes If yes, explain_____

_____

what are some areas of concern for you?

- ☐ Forehead
- ☐ Crows Feet
- ☐ Between the brows
- ☐ Laugh Lines
- ☐ Thin lips
- ☐ Loose skin
- ☐ Lose in volume
- ☐ Other

Female Clients:

Are you pregnant? Yes No Are you breastfeeding? Yes No

Is there a possibility you could be pregnant in the near future? Yes No

Are you currently on an type of hormone therapy? Yes No

If yes, please describe:

Skin Self- Analysis

Ethnicity (please check all that apply, even if you are a combination of the below)

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/ Latin ☐ Mediterranean

☐ Middle Eastern ☐ Native American ☐ Other:_____

Which of the following describes your skins most common reaction to sun exposure:

- ☐ Always burns, never tans
- ☐ Usually burns, tans with difficulty
- ☐ Sometimes burns and tans moderately
- ☐ Burns minimally, tans with ease
- ☐ Rarely burns, tans very easily
- ☐ Never burns, tans very easily

Are you currently using a tanning bed, self tanner, or sunbathed? No Yes

Last date of prolonged sun exposure:

Are you currently using any of these products in your regimen?

- ☐ Cleanser
- ☐ Serums
- ☐ Chemical Exfoliant (AHAs, BHAs)
- ☐ Physical Exfoliant (Granules)
- ☐ Tretinoin/ Retin- A
- ☐ Retinol
- ☐ Moisturizer
- ☐ Essence/ Toners
- ☐ Face masks
- ☐ Sheet masks
- ☐ Sun Screen
- ☐ Eye Creams

Patient Name:_____ Date:_____

_____

Patient Signature