MARLOWE MD
& MARRS MD
ENT + AESTHETICS

Patient Name: ________________________________ DOB:______________ Female/ Male

Phone: ____________________ Email: ______________________ Preferred Pharmacy: ___________________

Address: ____

How did you hear about us? ____

Age: ________ Height: _________ Weight: _________ PCP: _______________________________

MEDICATIONS

Please circle if you take any of the following: Aspirin - Ibuprofen - Fish Oil - Herbal Supplements

Please list ALL other medications you are currently taking and for what reason you take the medication: __________

____

____

ALLERGIES

Please circle if you have ever had an allergic reaction to any of the following: Tape - Iodine - Latex - Medications

Food - Aspirin - Epinephrine - Hydroquinone/ Bleaching Agents - Lidocaine/ Any Topical Anesthetic - Hydrocortisone

Please list ALL other known allergies and reactions: ____

MEDICAL HISTORY

Please circle any of the following that apply to you:

Cancer - Diabetes - High Blood Pressure - Herpes - Arthritis - Cold Sores - HIV/AIDS - Keloid Scarring - Skin Lesions

Acne - Rosacea - Pigmentation - Other Skin Disease - Seizer Disorder - Hepatitis - Hormone Imbalance

Thyroid Imbalance - Blood Clotting - Abnormalities - Migraines - Bleeding Disorders - Any Active Infection

No Known Ailments

MEDICAL HISTORY CONTINUED

Do you have any other medical conditions or concerns? ____

____

Are you currently taking oral birth control? YES / NO

Are you pregnant or trying to become pregnant? YES / NO

Are you breast feeding? YES / NO

Do you currently wear contact lenses? YES / NO

Are you currently under a physician's care for any skin conditions? YES / NO

LIFESTYLE

Are you currently on a special diet? YES / NO

Do you exercise regularly (at lease 3 times per week for 30 minutes or more)? YES / NO

Do you smoke? YES / NO If yes, how many cigarettes per day? ______________________

Do you drink alcohol? YES / NO Number of drinks ________ per day / week / month

Do you recreationally use drugs? YES / NO

SKINCARE

Which of the following best describes your skin when exposed to the sun for 1 hour without SPF protection?

- I – Always Burns, Never Tans
- II – Always Burns, Sometimes Tans
- III – Sometimes Burns, Always Tans
- IV – Rarely Burns, Always Tans
- V – Brown Skin
- VI- Black Skin

What us your current sunscreen regimen? ____

Have you ever taken Accutane? If yes, when was your last dose of Accutane? ____________________________

Have you used Retin-A or any powerful alpha hydroxy acids within the past 3 months? ___________________________

Have you ever had an adverse reaction to products or skincare treatments/ lasers? YES / NO

Have you ever had any of the following treatments? (Circle all that apply)

Chemical Peel - Facial - IPL Photofacial - Waxing - Laser Hair Removal - CO2 Fractional Laser - CoolSculpting
WarmSculpting - Tattoo Removal - Botox - Fillers Other: ____

Have you used the following hair removal methods over the past six weeks? (Circle all that apply)

Shaving - Waxing - Tweezing - Threading - Electrolysis - Depilatories

SKINCARE CONTINUED

Have you had any recent sun exposure or tanning that has changed the color of your skin? YES / NO

Have you recently (within the last 2 weeks) used any self-tanning lotions? YES / NO

When were you last exposed to the sun or a tanning bed?

____

Do you form thick or raised scars from cuts or burns? YES / NO

Do you bruise easily? YES / NO

Do you have hyperpigmentation (darkening of the skin), hypopigmentation (lightening of the skin), or neither after physical trauma or the skin being cut? HYPER / HYPO / NEITHER

Do you currently have permanent make-up? YES / NO

Have you ever been treated for pigmentation? YES / NO

CONCERNS

Please circle the following topics that you would like to address in today's consultation:

Botox	Fillers	Sun Spots/Uneven Pigmentation
Cellulite Treatments	Body Contouring	Skin Resurfacing
Skin Rejuvenation	Laser Resurfacing	Skin Tightening
Tattoo Removal	Laser Hair Removal	Skincare Products

Emergency Contact: ____________________ Relationship: ________________ Phone: _______________

_______The information I have provided is accurate and to the best of my knowledge. I agree to accept responsibility for the omissions regarding my failure to disclose any existing or past health conditions.

_______ I authorize the use and disclosure of my photographic/video images, and/ or testimonial for marketing purposes on our social media. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. I understand I may revoke this authorization at any time, but it must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.

____ ______________________________

Patient Signature Date