MARLOWE MD
& MARRS MD
ENT + AESTHETICS

Patient Name: _____ DOB:_____ Female/ Male

Phone: _____ Email: _____ Preferred Pharmacy: _____

Address: _____

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 - Hvdrocortisone

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

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

LIFESTYLE

Are you currently on a special diet? YES / NO

Do you exercise regularly (at least 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 is 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:

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

Your healthcare is important to us, you are currently set to receive emails, phone calls or text messages for appointment reminders and healthcare updates.

To better assist your healthcare needs do you also wish to receive special offers, promotional updates, and information about exclusive events for the products and services we offer? Yes No

If yes, please fill below

Cell Phone #: Email:

Client Signature: Date:

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.

_____

_____

Please circle below topics you would like to address in today's consultation:

Wrinkles (Botox)	Facial Volume Loss (fillers)	Weight Loss
Sunspots/Pigmentation	Uneven skin texture	Urinary Incontinence
Cellulite Treatments	Body Contouring	Skin Resurfacing
Skin Rejuvenation	Skin Tightening	Sexual Wellness
Tattoo Removal	Laser Hair Removal	Skincare Products
Other: _____		

We are proud providers of Emsculpt NEO, the GOLD standard in non-invasive body contouring

25% Muscle Increase I 30% Fat Reduction I FDA Cleared I Effective I No Downtime

Circle your areas of opportunity below

SELF-ASSESSMENT

Please complete and return this form to the front office before your consultation.

NAME: _____ DATE OF BIRTH: _____ DATE: _____

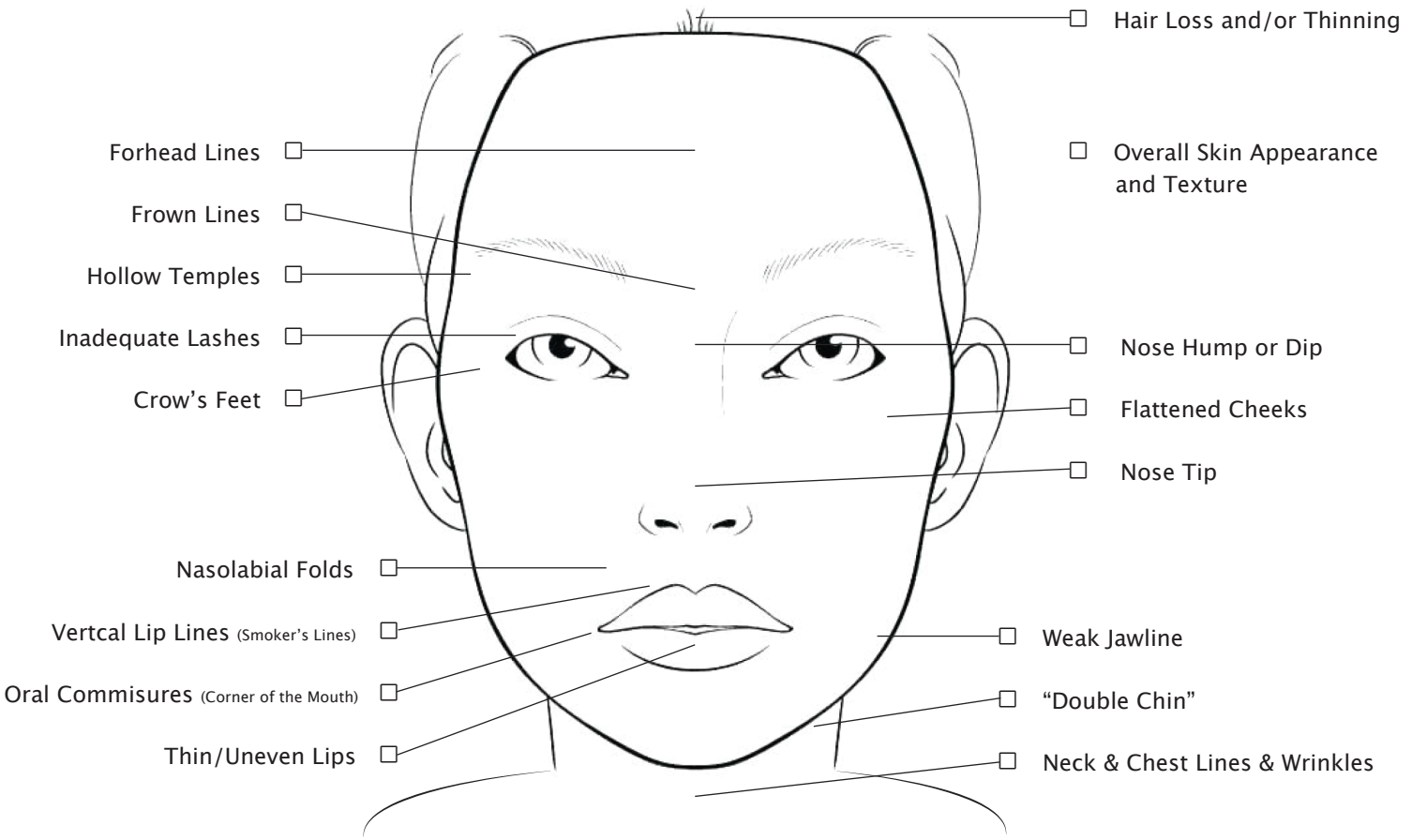
What brings you in today? _____

Other than the services we have already provided for you, what additional services would like to learn about? Please check all that apply.

❑ Skin care advice	❑ Facial veins	❑ Scar revision
❑ Skin care products	❑ Facial redness	❑ Breast size
❑ Facial injectables/fillers	❑ Brown spots/age spots/freckles	❑ Abdominal area
❑ Facial fine lines/wrinkles	❑ Drooping brow	❑ Hips
❑ Thin lips	❑ Drooping eyelids	❑ Legs
❑ Length of eyelashes	❑ Nose size or shape	❑ Facial contouring
❑ Fullness of eyelashes	❑ Facial fullness/drooping	❑ Body contouring
❑ Darkness of eyelashes	❑ Mole removal	❑ Unwanted hair
❑ Chemical peel	❑ Neck wrinkles	
❑ Blotchy skin	❑ Make up	

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Your Top 3 Areas of Concern:

1.

2.

3.

Your Treatment Plan Timeline (FOR OFFICE USE ONLY)