Microneedling Consultation & Pre-Treatment Intake

T&R Clinic, P.A. · Anum Ali, FNP-C

Printable copy - complete by hand and bring it to your appointment, or fill this form out online.

PATIENT INFORMATION

Full legal name: _____

Date of birth: _____

Age: _____

Sex: _____

Home address: _____

City: _____

State: _____

ZIP code: _____

Primary phone number: _____

Secondary phone number: _____

Email address: _____

Emergency contact name: _____

Emergency contact relationship: _____

Emergency contact phone number: _____

Primary care provider: _____

Primary care provider address: _____

Primary care provider phone number: _____

REASON FOR VISIT

What concerns would you like to address today? (check all that apply):

- ☐ Acne scars
- ☐ Fine lines / wrinkles
- ☐ Uneven skin texture
- ☐ Enlarged pores
- ☐ Hyperpigmentation / melasma
- ☐ Stretch marks
- ☐ Sun damage
- ☐ Surgical scars
- ☐ Hair restoration
- ☐ Skin tightening / rejuvenation
- ☐ Other

Other concern: _____

How long have these concerns been present?: _____

What results are you hoping to achieve?:

MEDICAL HISTORY

Optional - fill in whatever applies to you.

Please check any medical conditions you currently have or have had in the past:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Autoimmune disease
- ☐ Bleeding disorder
- ☐ Blood clotting disorder
- ☐ History of keloid or hypertrophic scarring
- ☐ Skin cancer
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Vitiligo
- ☐ Active acne
- ☐ Thyroid disorder
- ☐ Seizure disorder
- ☐ Cancer history
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Immune suppression
- ☐ Pregnancy
- ☐ Breastfeeding
- ☐ Other
- ☐ None of the above

Other condition: _____

ALLERGIES

Do you have any allergies? (choose one):

- ☐ Yes
- ☐ No

Please list all allergies and reactions (medications, latex, foods, topical products, adhesives, etc.):

VACCINATIONS

Have you received any vaccinations in the last two weeks (14 days)? (choose one):

- ☐ Yes

- [ ] No

Please list the vaccinations and the dates you received them:

HERPES SIMPLEX VIRUS (HSV) HISTORY

HSV is a common viral infection that may cause cold sores or fever blisters. Treatment around the face may occasionally trigger an outbreak in individuals with a history of HSV.

Have you ever had (check all that apply):

- [ ] Cold sores
- [ ] Fever blisters
- [ ] Oral herpes (HSV-1)
- [ ] Genital herpes (HSV-2)
- [ ] No known history of HSV

Date of most recent outbreak:

Frequency of outbreaks:

Are you currently taking antiviral medication? (choose one):

- [ ] Yes
- [ ] No

Antiviral medication name and dosage:

MEDICATIONS & SUPPLEMENTS

List ALL prescription medications, over-the-counter medications, vitamins, herbal supplements, injections, hormones, and topical products you currently use (name, dosage, reason for use). Write "None" if you take none.:

Are you currently taking any of the following?:

- [ ] Aspirin
- [ ] Ibuprofen / NSAIDs
- [ ] Blood thinners
- [ ] Steroids
- [ ] Retinoids / Retin-A / Tretinoin
- [ ] Accutane / Isotretinoin (within past 12 months)
- [ ] Antibiotics
- [ ] Immunosuppressive medications
- [ ] Hormone therapy
- [ ] Weight loss medications
- [ ] Biologic medications
- [ ] None of the above

SKIN & AESTHETIC HISTORY

Optional - fill in whatever applies to you.

Please check any procedures or treatments you have had:

- ☐ Botox / Dysport / Xeomin
- ☐ Dermal fillers
- ☐ Microneedling
- ☐ Chemical peels
- ☐ Laser treatments
- ☐ Facials
- ☐ PRP / PRF
- ☐ Plastic surgery
- ☐ Other
- ☐ None of the above

Approximate dates / details of the procedures checked above:

Have you ever experienced complications from a cosmetic procedure? (choose one):

- ☐ Yes
- ☐ No

Please explain:

Do you currently have any of the following?:

- ☐ Open wounds
- ☐ Active rash
- ☐ Skin infection
- ☐ Active cold sore
- ☐ Sunburn
- ☐ Recent tanning
- ☐ Recent waxing
- ☐ Recent facial surgery
- ☐ Recent facial injections
- ☐ None of the above

LIFESTYLE & SKINCARE

Do you smoke or use nicotine products? (choose one):

- ☐ Yes
- ☐ No

Do you consume alcohol regularly? (choose one):

- ☐ Yes
- ☐ No

Drinks consumed per week:

How often are you exposed to the sun? (choose one):

- ☐ Minimal
- ☐ Moderate
- ☐ Frequent

Do you use sunscreen regularly? (choose one):

- ☐ Yes
- ☐ No

Current skincare products used. Write "None" if you use none.:

PATIENT ACKNOWLEDGMENT

I certify that the information provided above is complete and accurate to the best of my knowledge. I understand that withholding medical information may increase the risk of complications or adverse reactions.

I understand that the provider may determine I am not an appropriate candidate for microneedling based on my medical history, medications, skin condition, or other factors.

Acknowledgment:

- ☐ I certify the above information is complete and accurate to the best of my knowledge.

Patient signature

Date: