

PROGRESSIVE MEDICAL GROUP, INC.
AESTHETIC SERVICES – PATIENT INTAKE FORM

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Phone: 414-251-3500 | Fax: 414-251-3504

PATIENT INFORMATION

Full Name: _____

Preferred Name: _____

Date of Birth: _____ **Age:** _____

Phone: _____

Email: _____

Address: _____

City/State/ZIP: _____

Emergency Contact: _____

Relationship: _____ **Phone:** _____

AESTHETIC CONSULTATION

What brings you in today?

- ☐ Botox/Anti-Wrinkle Injections
- ☐ Dermal Filler
- ☐ SkinPen/Microneedling
- ☐ PRP
- ☐ Skin Rejuvenation
- ☐ Fine Lines/Wrinkles
- ☐ Acne Scarring
- ☐ Skin Texture
- ☐ Uneven Skin Tone/Pigmentation
- ☐ Lip Enhancement

- ☐ Facial Contouring
☐ Other: _____

Areas of concern

- ☐ Forehead lines
☐ Frown lines/"11s"
☐ Crow's feet
☐ Brow area
☐ Lips
☐ Lip lines
☐ Cheeks
☐ Nasolabial folds
☐ Marionette lines
☐ Chin
☐ Jawline
☐ Neck
☐ Acne scars
☐ Other: _____

What would you most like to improve?

Have you received aesthetic treatments before?

- ☐ No
☐ Yes

If yes, please list treatments and approximate dates:

Have you had any previous complications from an aesthetic or cosmetic treatment?

- ☐ No
☐ Yes

If yes, please explain:

MEDICAL HISTORY

Please check **YES** or **NO**.

Medical History	Yes	No
Heart disease	☐	☐
High blood pressure	☐	☐
Diabetes	☐	☐
Bleeding or clotting disorder	☐	☐
Easy bruising or excessive bleeding	☐	☐
Autoimmune condition	☐	☐
Immune system disorder	☐	☐
Active infection	☐	☐
Skin disease/condition	☐	☐
History of abnormal scarring/keloids	☐	☐
Cold sores/herpes	☐	☐
Severe allergies	☐	☐
Latex allergy	☐	☐
Allergy to local anesthetics	☐	☐
Recent surgery	☐	☐
History of facial surgery	☐	☐
History of cancer	☐	☐
Neuromuscular disorder	☐	☐
Pregnancy	☐	☐

Breastfeeding

☐ ☐

If yes to any item, please explain:

MEDICATIONS AND SUPPLEMENTS

Current prescription medications:

Over-the-counter medications:

Vitamins/herbal supplements:

Are you currently taking medications or supplements that may increase bleeding or bruising?

- ☐ No
- ☐ Yes
- ☐ Unsure

If yes, please list:

Do not stop any prescribed medication without discussing it with your prescribing healthcare professional.

ALLERGIES

Do you have any medication, food, latex, or other allergies?

☐ No known allergies

☐ Yes

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

SKIN HISTORY

Do you currently have any of the following in the area you want treated?

☐ Open wound

☐ Active rash

☐ Active acne flare

☐ Skin infection

☐ Cold sore

☐ Sunburn

☐ Significant irritation

☐ None

If applicable, please explain:

Have you recently had significant sun exposure or tanning?

☐ No

☐ Yes

Have you used prescription or medical-grade skin products recently?

☐ No

☐ Yes

If yes, please list:

RECENT PROCEDURES & TREATMENTS

Please tell us if you have recently had:

☐ Botox/anti-wrinkle injections

Date: _____

☐ Dermal filler

Date: _____

☐ Microneedling/SkinPen

Date: _____

☐ Chemical peel

Date: _____

☐ Laser/IPL treatment

Date: _____

☐ PRP

Date: _____

☐ Facial surgery

Date: _____

☐ Dental procedure

Date: _____

☐ Other: _____

Date: _____

PREGNANCY & BREASTFEEDING

Are you currently pregnant?

☐ No ☐ Yes ☐ Not applicable

Are you currently breastfeeding?

☐ No ☐ Yes ☐ Not applicable

Are you planning pregnancy in the near future?

☐ No ☐ Yes ☐ Unsure

I understand that certain aesthetic treatments may be postponed depending on pregnancy, breastfeeding status, medical history, medications, or other clinical considerations.

LIFESTYLE INFORMATION

Do you smoke or use nicotine products?

☐ No ☐ Yes

Alcohol use:

☐ None ☐ Occasional ☐ Regular

Do you use recreational drugs?

☐ No ☐ Yes

If yes, please explain:

TREATMENT EXPECTATIONS

What is most important to you regarding your aesthetic treatment?

- ☐ Natural-looking improvement
- ☐ Noticeable improvement
- ☐ Skin rejuvenation
- ☐ Smoother skin
- ☐ Improved facial balance

- ☐ Improved skin texture
- ☐ Reduced appearance of wrinkles
- ☐ Other: _____

How would you describe your desired result?

I understand that aesthetic treatments are intended to improve the appearance of the treated area and that **specific results cannot be guaranteed**.

COMMUNICATION PREFERENCES

I authorize Progressive Medical Group to contact me regarding my appointments, treatment-related communications, and practice-related matters using the information I provide.

Preferred contact method:

- ☐ Phone
- ☐ Voicemail
- ☐ Text
- ☐ Email
- ☐ Patient Portal

Best phone number: _____

PHOTOGRAPHY

I understand that photographs may be taken before, during, and/or after my aesthetic treatment for clinical documentation and treatment planning.

Any authorization for use of photographs for marketing, advertising, website, or social media purposes will be addressed through a **separate photography authorization**.

☐ I understand.

PATIENT ACKNOWLEDGMENT

I certify that the information provided on this form is accurate and complete to the best of my knowledge.

I understand that I should inform Progressive Medical Group of any changes to my medical history, medications, allergies, pregnancy status, skin condition, or other information that may affect my treatment.

I understand that completion of this intake form **does not constitute consent to a specific aesthetic procedure**. Separate informed consent may be required before Botox/anti-wrinkle injections, dermal fillers, SkinPen/microneedling, PRP, or other aesthetic procedures.

I understand that my provider may determine that a treatment should be postponed, modified, or not performed based on my medical history, examination, treatment area, or other clinical considerations.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider/Staff Name: _____

Provider/Staff Signature: _____

Date: _____

FOR OFFICE USE ONLY

Treatment Requested: _____

Treatment Area: _____

Provider: _____

Consultation Date: _____

Medical History Reviewed: ☐ Yes ☐ No

Medications Reviewed: ☐ Yes ☐ No

Allergies Reviewed: ☐ Yes ☐ No

Pregnancy/Breastfeeding Status Reviewed: ☐ Yes ☐ No ☐ N/A

Contraindications/Precautions Identified: ☐ No ☐ Yes

Additional Notes:

Treatment Approved: ☐ Yes ☐ No ☐ Defer/Additional Evaluation

Provider Initials: _____