



# A E S T H E T I C D E R M A T O L O G Y

Ann Zedlitz MD, FAAD

5305 Flanders Drive Baton Rouge LA 70808 / 17497 Old Jefferson Hwy. Prairieville, LA 70769

Phone: (225) 778-7540 Fax: (225) 778-7548

Email: [info@zdermatology.com](mailto:info@zdermatology.com) Website: [zdermatology.com](http://zdermatology.com)

## Patient Intake Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What are your primary concerns? (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Fine Lines / Wrinkles/ Volume Loss                | <input type="checkbox"/> Enlarged Pores                   |
| <input type="checkbox"/> Preventative Anti-Aging                           | <input type="checkbox"/> Dullness                         |
| <input type="checkbox"/> Under Eyes / Upper Eyelids                        | <input type="checkbox"/> Redness or Rosacea               |
| <input type="checkbox"/> Facial Contouring / Jawline Contouring            | <input type="checkbox"/> Stretch Marks                    |
| <input type="checkbox"/> Lip Shape / Nose Shape / Size                     | <input type="checkbox"/> Urinary Stress Incontinence      |
| <input type="checkbox"/> Sagging / Skin Laxity / Neck Bands                | <input type="checkbox"/> Vaginal Rejuvenation             |
| <input type="checkbox"/> Skin Resurfacing / Crepiness                      | <input type="checkbox"/> Fat Reduction / Weight Loss      |
| <input type="checkbox"/> Acne / Breakouts                                  | <input type="checkbox"/> Jaw Clenching or TMJ             |
| <input type="checkbox"/> Scars / Texture                                   | <input type="checkbox"/> IV Therapy / B12, NAD+ injection |
| <input type="checkbox"/> Body Contouring                                   | <input type="checkbox"/> Hair Loss                        |
| <input type="checkbox"/> Pigmentation / Melasma / Sun Damage / Uneven Tone | <input type="checkbox"/> Other: _____                     |

Briefly describe your aesthetic goals: \_\_\_\_\_

What are you interested in learning more about or considering today?

(Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Relaxant (Botox, Dysport, etc.) | <input type="checkbox"/> Microneedling          |
| <input type="checkbox"/> Fillers                         | <input type="checkbox"/> PRP Therapy            |
| <input type="checkbox"/> Laser Treatments                | <input type="checkbox"/> Medical-Grade Skincare |
| <input type="checkbox"/> Chemical Peels                  | <input type="checkbox"/> Other: _____           |

## Skin History

Have you ever been diagnosed with or experienced any of the following?

(Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Acne                              | <input type="checkbox"/> Skin Sensitivity / Allergic Reactions |
| <input type="checkbox"/> Rosacea                           | <input type="checkbox"/> Hyperpigmentation                     |
| <input type="checkbox"/> Eczema                            | <input type="checkbox"/> Keloid or Hypertrophic Scarring       |
| <input type="checkbox"/> Psoriasis                         | <input type="checkbox"/> History of Skin Cancer                |
| <input type="checkbox"/> Melasma                           | <input type="checkbox"/> Other: _____                          |
| <input type="checkbox"/> Cold Sores / Herpes Simplex Virus | <input type="checkbox"/> None                                  |

Other relevant skin concerns or history we should know about:

\_\_\_\_\_

## Current Skincare Products

Please list or describe the products you're currently using (if applicable):

- **Cleanser(s):** \_\_\_\_\_
- **Serums / Treatments:** \_\_\_\_\_
- **Moisturizer(s):** \_\_\_\_\_
- **Other Products:** \_\_\_\_\_

Do you currently use any of the following? (*Check all that apply*)

- |  |  |
|--|--|
| <input type="checkbox"/> Sunscreen (daily use)     | <input type="checkbox"/> Prescription medications for skin |
| <input type="checkbox"/> Hydroquinone (HQ)         | <input type="checkbox"/> Topical Antibiotics               |
| <input type="checkbox"/> Vitamin C                 | <input type="checkbox"/> Other: _____                      |
| <input type="checkbox"/> Retinol/Retin-A/Tretinoin | <input type="checkbox"/> None                              |

## Previous Aesthetic Treatments

Have you received any of the following treatments in the past?

Treatment	Ever Had?	Approx. Date	Satisfied?
Relaxant (Botox, Dysport, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermal Fillers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Laser Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Microneedling / RF	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Peels	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
PRP	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Facials	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Any complications, reactions, or concerns from past treatments?**

\_\_\_\_\_

**Any known allergies?**  No  Yes: \_\_\_\_\_

**Medications:** Please list all home medications, vitamins, minerals, or herbal supplements:

\_\_\_\_\_

## Consent & Acknowledgement

I confirm the above information is accurate to the best of my knowledge. I understand that this information is used to help guide my aesthetic consultation and treatment plan. I will inform my provider of any changes.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_