



New Patient Intake Form — Jax Med

Date: _____

Patient Information

- Name: _____ Date of Birth: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Work Phone: _____ Cell: _____
- Email: _____
- Emergency Contact Name: _____ Phone: _____
- How did you hear about us? _____

Medical History: Please check any conditions you have or have had:

- | | | |
|---|--|---|
| ☐ Allergy/hay fever | ☐ Dizziness/fainting | ☐ Lupus |
| ☐ Anemia | ☐ Drug or alcohol use | ☐ Melanoma |
| ☐ Arthritis/rheumatism | ☐ Epilepsy | ☐ Mental disorder |
| ☐ Asthma | ☐ Eye injury/disease | ☐ Migraines |
| ☐ Back problems/pain | ☐ Headaches | ☐ Mitral valve prolapses |
| ☐ Bleeding problems | ☐ Heart disease | ☐ Nervousness |
| ☐ Blood transfusion | ☐ High blood pressure | ☐ Radiation treatment |
| ☐ Cancer | ☐ Infection (active) | ☐ Respiratory problems |
| ☐ Chemotherapy | ☐ Kidney disease | ☐ Shingles (past outbreak) |
| ☐ Diabetes | ☐ Liver disease | |

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Other: _____

Skin Care History

Current skin care products: _____

Previous cosmetic facial treatments (check all that apply):

- | | | |
|---|--|---|
| ☐ Retin-A / Renova / Retinoic acid | ☐ Pregnant / Lactating
(Due:_____) | ☐ Tattoo/ Permanent makeup |
| ☐ Accutane | ☐ Cold sore history | ☐ Facial surgery |
| ☐ Birth control pills / patch | ☐ Fever blister history | ☐ Microdermabrasion |
| ☐ Steroids | ☐ Chemical peel | ☐ Cellulite treatments |
| ☐ Insulin /Diabetic medications | ☐ Botox® | ☐ Laser treatments |
| | ☐ Dermal fillers | ☐ Tanning (last 2 weeks) |

Acknowledgment & Consent

I certify that the above information is true and complete to the best of my knowledge. I understand that withholding information or providing false information may result in contraindications for certain treatments.

Patient Name (Print): _____

Patient Signature: _____