VILLANO | MD
TIMELESS BEAUTY | BEND

Patient Name:
Patient Account Number:

PATIENT INFORMATION

Last name: ______________________ First name: ______________________ Middle initial: ________

Date of Birth: ______________ Gender: Male Female SSN: ________________ Marital Status: M S W D

Phone (H): ______________ Phone (W): ______________ ext. ________ Phone (C): ______________

May we leave a message? Yes __________ No __________

Address: ______________________________ City/State: ________________ Zip:________

Email: ____

May we email you product/service special offers or seminar information at this address: Yes No

REFERRED BY: (please specify in the space provided)

Self______________________ Relative______________________

Bulletin______________________ Another patient______________________

Magazine______________________ Spa/Salon______________________

Yellow Pages______________________ Employee______________________

Friend______________________ Other______________________

Seminar______________________ Physician______________________

Website______________________ Internet______________________

REASON FOR TODAY'S VISIT: ____

AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION

I authorize Cascade Faces Aesthetics and Facial Plastic Surgery Center to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Cascade Faces Aesthetics and Facial Plastic Surgery Center determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Cascade Faces Aesthetics and Facial Plastic Surgery Center.

Signature: ______________________________ Date: ______________

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PATIENT HISTORY

First Name: ______________________ Last Name: ______________________

Date of Birth:______________ Age:________Date: ______________________

Height: __________ Weight: __________ Current Weight Loss? __________

Are you currently pregnant or lactating? _______ Have you ever been pregnant? _______

During pregnancy, did you experience hyper pigmentation? ______________________

Areas: ______________ Comments: ______________________

Do you currently have regular periods? ______________________

Are you currently going through menopause? ______________________

Do you wear contact lenses? _______ Do you use tanning booths? __________

Do you currently have a sunburn or windburn? _______ Area: ______________

Do you currently have waxing / electrolysis treatments? _______ Area: __________

Are you currently using Biore' or other acne strips? _______ Area: __________

Are you currently using Retin-A, Renova or Differin? _______ Strength: __________

How frequently? __________ Area: __________ For how long? __________

Are you currently using Acutane? __________ For how long? __________

Are you currently having microdermabrasion? _______ For how long? __________

Do you have regular filler (Restylane, Collagen, etc.) injections? _______ Last injection? __________

Do you have regular Botox injections? __________ Last injection? __________

What type of work do you do? ______________________

Do you participate in vigorous aerobic activity and how often? ______________________

Have you ever had a peel? ______________ Date of last peel? __________

Type of peel? __________ Describe your reaction? ______________________

Have you recently had facial surgery? __________ Type and date: __________

Have you ever had laser resurfacing? __________ Type and date: __________

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Do you smoke? ____________________ Packs per week and for how long: __________________

Do you develop cold sores or fever blisters? __________ Last breakout: ______________

Are you allergic or sensitive to any of the following? Please check all that apply

Milk	______________	Citrus	______________	Aloe Vera	______________
Apples	______________	Grapes	______________	Aspirin	______________
Perfumes	______________	Latex	______________	Hydroquinone	______________

Any other allergies? ____

Are you sensitive to alcohol based products? ____

Are you taking any medications at this time, over-the-counter or RX? ________________________

Describe your skin from the following choices, please check all that apply.

Thick	______________	Thin	______________	Saggy	______________
Firm	______________	Normal	______________	Dry	______________
Combination	______________	Oily	______________	Acne Prone	______________
Comedones	______________	Milia	______________	Cystic	______________
Breakouts	______________	Scarred	______________	Large Pores	______________
Small Pores	______________	Florid	______________	Rosacea	______________
Eczema	______________	Freckled	______________	Sun-damaged	______________
Uneven/Blotchy	______________	Mature	______________	Wrinkled	______________
Patchy Dryness	______________	Sallow	______________	Melasma	______________
Perfume-stained	______________	Hypo-Pigmentation	_______	Hyper-Pigmentation	___________
Psoriasis	______________	Dehydrated	______________	Asphyxiated	______________
Broken Capillaries	____________				

Which of the following do you consider your skin to be? Please check one of the following

Sensitive	______________	Resilient	______________	Not Sure	______________

Eye color:

Blue	______________	Green	______________	Gray	______________
Light Brown	______________	Medium Brown	______________	Dark Brown	______________

Natural hair color:

Blonde	______________	Red	______________	Light Brown	______________
Medium Brown	________	Dark Brown	______________	Black	______________
Gray/Silver	___________				

Skin tone:

Pale/ white	______________	Light	______________	Medium	______________
Reddish	______________	Freckled	______________	Light Olive	______________
Medium Olive	______________	Dark Olive	______________	Light Brown	______________
Medium Brown	______________	Dark Brown	______________	Soft Black	______________
Black	______________	Sallow	______________		

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What is your hereditary make-up? ____

Are you using glycolic / AHA home care products? __________ Please list: ______________

How does your skin react to them? ____

Have you ever used any products that cause a bad reaction? ________________________

What is your daily home care regimen? ____

What are the cosmetic improvements you would like to see in your skin? ______________________

____

Any comments: ____

____

____

____

____

Patient Signature: ____

Aesthetician Signature: ____