Nathan Eberle
DDS MD FACS

Patient Name:_____ DOB:_____ Age: _____Date: _____

We ask that all clients complete this profile prior to receiving any service. We use this information to accurately evaluate our client's specific needs. This information is completely confidential and used for analysis purposes only. Thank You.

1. Do you have any health problems? Check all that apply:

- ☐ Headaches
- ☐ Fatigue
- ☐ Blood Clots
- ☐ Arthritis
- ☐ Heart Problems
- ☐ Bruise Easily
- ☐ Skin Sensitivity
- ☐ Difficulty Breathing
- ☐ Rosacea
- ☐ Back or Spinal problems
- ☐ Gastrointestinal
- ☐ Varicose Veins
- ☐ Pregnant or Lactating
- ☐ (High/Low) Blood Pressure
- ☐ Hormonal Imbalance
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Claustrophobia
- ☐ Thyroid (overactive/underactive)
- ☐ Implants (pacemakers, pins in bones, etc.)
- ☐ Cancer _____
- ☐ Other Skin Problems _____
- ☐ Allergies/Sensitivities

1. Do you experience these conditions on your skin?

- ☐ Flakiness ☐ Tightness ☐ Bruising
- ☐ Oiliness ☐ Breakouts ☐ Redness

2. Are you using and acne/aging products (oral or topical)?

- ☐ Retin-A ☐ Renova ☐ Accutane
- ☐ Differin ☐ Azelex ☐ Other

3. Have you ever had a reaction to any of the following?

- ☐ Shellfish/iodine ☐ Medicine ☐ Makeup
- ☐ Sunscreens ☐ Fragrance/Dyes ☐ AHA's
- ☐ Other _____

5. Have you been under a physician's care recently? ☐Yes ☐No
6. Do you wear contact lenses? ☐Yes ☐No
7. Do you sun bathe or use tanning beds? ☐Yes ☐No
8. Are you using oral contraceptives? ☐Yes ☐No
9. Do you use sunscreen? ☐Yes ☐No
10. Have you had Microdermabrasion, chemical peels or laser peels before? ☐Yes ☐No
11. Do you smoke (including socially)? ☐Yes ☐No
12. Do you follow a specialized diet? ☐Yes ☐No
13. How many times a week do you exercise? _____
14. How many 8oz. glasses of water do you consume daily? _____
15. How many 8oz. caffeinated beverages do you consume daily? _____
16. How many alcoholic beverages do you consume **weekly?** _____

17. List any medications, vitamins and supplements you take regularly: _____
18. Do you currently have any skin ailments (poison ivy, eczema, etc.)? _____
19. What is your primary goal or improvements you would like to see? _____
20. What skin care program are you currently using (cleanser, etc.)? _____
21. Please list recent surgeries, hospitalizations, major illnesses and accidents. (Please include dates)

Questions to be updated every visit:

22. Are you currently having or due for your menstrual cycle? ☐Yes ☐No
23. Have you started any new medication, treatments or skin care products? ☐Yes ☐No if yes, specify:
24. Will you be returning to work or another social setting after your treatment session today? ☐Yes ☐No

I confirm that to the best of my knowledge, the answers I have given are correct and I have not withheld any information. I will inform my practitioner of any changes in my health or lifestyle which may affect my treatment.

Client's Signature: _____ Date: _____