Dalla Riva
Medical Cosmetics

New Patient Information

Name: ___________________________ Birth Date: _____ /_____ /_____ Age: _______
E-mail: ____
Address: ____ Sex: M / F
City: ___________________________________ State: _____ Zip Code: ____________
Home: (____)_______________ Work: (____) ____________ Cell: (____)______________
Emergency Contact: ______________________ Telephone: (_____) ___________________
Allergies: ____
For women: LMP: ______________________
How did you hear about Dalla Riva Medical Cosmetics? ________________________________

Please put a check mark next to the procedures about which you would like to receive more information:

___ Wrinkle treatment
___ Products to reduce and prevent wrinkles
___ Enhanced skin rejuvenation
___ Collagen augmentation products
___ Acne treatment
___ Skin toning or pore size reduction
___ Products to reduce and prevent acne
___ Brown spots
___ Sun damage
___ Broken capillaries
___ Spider veins/leg veins
___ Hair reduction
___ Shaving bumps/ingrown hair
___ Facial redness

Medical History

Please put a check mark next to a past or current medical condition:

___ Lupus or other auto-immune deficiency (A)
___ Rheumatoid arthritis "Gold" therapy (A)
___ Currently pregnant (A)
___ Bleeding abnormalities (A)
___ Accutane® in the last year (A)
___ Tetracycline® in the last month (A)
___ Keloid or very thick scarring (A)
___ Psoriasis (A)
___ Pulmonary embolism/blood clot (V)
___ Leg ulcer or phlebitis (V)
___ Blood thinning medication (V)
___ Coumadin®/anti-clotting agents (A)
___ Cystic Acne (P)
___ Herpes simplex or fever blisters (A)
___ Diabetes (A)
___ Light sensitive epilepsy (A)
___ Scars that turn white or brown (A)
___ Dark spots after pregnancy, skin injury (A)
___ HIV (A)
___ Hepatitis (A)
___ Waxing/plucking/electrolysis within last four weeks (HR)
___ Hirsutism (HR)
___ Transplant anti-rejection drugs (HR)
___ Chemical peels, dermabrasion, laser Resurfacing or face lift (A)
___ Tattoos/permanent make-up (A)
___ Polycystic ovarian disease (PCOD)
___ Implants (Location:______________)
___ Collagen injection (Location:_________)
___ Photosensitizing drugs such as PDT

Please list any medications or herbal supplements that you are currently taking:

_______________________________ ____________
Patient Signature Date

(A) all treatments, (V) vascular treatments, (HR) hair removal/pseudofolliculitis, (P) micro & weekend peels

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