Oncology Aesthetics
Patient Information Form

Name: _____Date:_____

Address: _____City_____Zip:_____

Email address: _____Date of Birth_____/_____/_____

Phone: (_____) _____-_____ Referred by: _____

Emergency Contact name _____Phone: (_____) _____ - _____

Doctor's Name _____ Phone: (_____) _____ - _____

SKIN:
Are you experiencing any skin issues? _____YES _____NO If yes, explain_____
_____

SCALP:
Are you experiencing any scalp issues? _____YES _____ NO If yes, explain_____
_____

Are you experiencing any hair loss? _____YES _____ NO Do you wear a wig? YES _____ NO _____

NAILS:
Are you experiencing any nail (finger or toe) issues? _____YES _____NO If yes, explain _____
_____

MEDICATIONS:
Chemotherapy? _____YES ____NO Date started Chemo: _____
Name of Chemo drug(s)
_____
_____
_____

Blood Thinners _____YES _____NO * Steroids? _____YES _____NO
Any other medications or supplements (including aspirin, vitamins):
_____
_____
_____

Current Skin Care products used:
_____
_____
_____