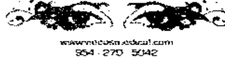
VIO CosMedical P.A.
4390 N. Federal Highway, Suite 105
Fort Lauderdale, FL 33308



954 · 270 · 5042

PATIENT PERSONAL INFORMATION Date ____/____/________

Name ____
Last Middle First

Address ____
Address City State Zip Code

Date of Birth ____________________ Employer ____________________

Age ____________________ Occupation ____________________

Cell Phone ____________________ Does your job require to work outside?

Home Phone ____________________ ○NO ○ YES

Work Phone ____________________ Who may we thank for referring you?

E-mail ____________________ Name ____________________

Next of Kin Name ____________________ Next of Kin E-mail ____________________

CURRENT SKIN CARE & CONDITION ** For an effective personalized treatment, please be as accurate as possible*

1. SKIN TYPE
○Normal ○Dry ○Oily ○Combination ○Mature ○Sensitive/Breakout ○Very Sensitive/Rosacea ○Acne

2. WHAT ARE YOUR PRESENT SKIN CONCERNS? (please check all that apply)
○Acne Lesions (cysts) ○Acne Scars ○Pustules (inflamed) ○ Blackheads ○Whiteheads
○Enlarged Pores ○Dilated Capillaries ○Ingrown Hair ○Hyperpigmentation (brown spots from sun, hormonal)

EYE AREA
○Wrinkles ○Deep Lines ○Lack of Elasticity ○Dark Shadow ○Puffiness

MOUTH AREA
○Wrinkles ○Hyperpigmentation

CHEEK AREA
○Lost of Elasticity ○Cross Wrinkling (sun damage) ○Uneven Texture ○Dilated Texture ○Dilated Pores ○Visible Capillaries

NECK AND DECOLETTE AREA
○Wrinkles ○Lack of Elasticity ○Severe Sun Damage ○Hyperpigmentation

3. HAVE YOU RECENTLY RECEIVED ANY OF THE FOLLOWING SPA SERVICES?
○Microdermabrasion Date ____/____/________
○Advanced Facial (using active ingredients) Date ____/____/________
○Acid Peels Date ____/____/________

4. HAVE YOU RECEIVED ANY OF THE FOLLOWING MEDICAL OR SURGICAL PROCEDURES?
○Rhytidectomy (Face Lift) ○Blepharoplasty (Eye Lift) ○Rhinoplasty (Nose)
○Laser Resurfacing Date ____/____/________ ○Restylane Injections ____/____/________
○Dermabrasion Date ____/____/________ ○Collagen Injections ____/____/________
○Botox® Date ____/____/________ ○Other: ____________________

5. HOW OFTEN DO YOU RECEIVE A FACIAL?
○ Regularly ○Seldom ○Never

6. WHICH BRANDS OF COSMETICS DO YOU CURRENTLY USE THE MOST?
____

7. ARE YOU PREGNANT OR ACTIVELY ATTEMPTING PREGNANCY? ○NO ○YES

8. DO YOU HAVE ANY BODY IMPLANTS? ○Pacemaker ○Prosthesis ○Metal

9. HAVE YOU BEEN PRESCRIBED Accutane®? Topical Vitamin A e.g. Retin A? ○NO ○YES When ____________________

10. ALLERGIC TO MEDICATION? ____________________

11. PLEASE LIST ANY ALLERGIES: ____________________

I declare that I am mentally and physically capable and responsible in determining that my state of health is suitable to receive services from VIO CosMedical P.A. and with my signature, I acknowledge and hereby agree that I will release, indemnify and hold harmless VIO CosMedical, P.A. and their affiliates, officers, directors, and agents from all loss and/or damages, including attorney's fees that I may have now or in the future resulting from any/all services received at any facilities of VIO CosMedical P.A. at any of its locations. I give permission to VIO CosMedical, P.A. to use before and after photographs of my skin for the purposes of advertising and teaching.

NAME: ____________________ SIGNATURE ____________________