Patient Medical History

***Today's date :_____**

***Name: _____Date of birth: _____ Current age: _____**

Address: _____

***Phone (Home/ Cell) : _____ E-mail address: _____**

Marital Status: _____ Single _____ Married Occupation: _____

***Emergency Contact: Name: _____Phone: _____**

How did you hear about us? _____ Name of person: _____/ _____Yelp _____/Google

***List all medications, hormone replacement therapy, and or supplements:**_____

*Have you ever been hospitalized or had surgery to your face or body ? If so, please list date and reason:_____

***Please check any condition that you currently have or have had in the past:**

____ Heart Problem
____ Diabetic
____ HIV
____ Lupus
____ Hepatitis
____ Auto Immune Disease
____ Bruise Easily
____ Poor Wound Healing
____ Claustrophobic
____ Asthma
____ Eczema
____ Psoriasis

____ Vitiligo
____ Keloid Scar
____ Pacemaker
____ Metal Implant
____ Seizure
____ Epilepsy
____ Anxiety/Depression
____ Hormone Imbalance (Estrogen/Testosterone/ Progesterone)
____ Hyper Thyroid / Hypothyroid

____ PCOS
____ Excessive Hair Growth
____ Excessive Hair Loss
____ Permanent Makeup
____ Tattoo
____ MS
____ ALS
____ Bell's Palsy
____ Cold Sores
____ Shingles
____ High Blood Pressure
____ Varicose Veins

***Put a check mark beside what you are allergic to? If yes, please explain: _____**

____ Latex
____ Drugs Medicine (ie: Penicillin, Codeine, Sulfa)
____ Lidocaine or other numbing agents
____ Sun

____ Cosmetics
____ Food
____ Animals
____ Sunscreens
____ Iodine
____ Pollen

____ Alpha or Beta acids
____ fragrance
____ Salicylic Acid
____ Shellfish

*Patient's are responsible for contacting the provider if there are any changes in any questions that has an * **Asterisk** and is **bolded.***

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What procedures are you interested in? Check all that apply

____ Laser Hair Removal
____ Broad band Light / IPL
____ Facial
____ Rejuvapen: Microneedling
____ Neuromodulators: Botox/Xeomin/Dysport
____ Dermal filler: Juvederm / Restylane / Radiesse
____ Gluteal Butt" enhancement
____ Cellulite Treatment
____ PRF for hair growth

Which of the following best describes your skin when exposed to the sun for 30 minutes & no SPF:

____ Always burns easily, never tans with very pale skin tone
____ Always burns, tans with a hint of color with very pale skin tone
____ Burns initially, tans gradually with light skin tone
____ Can burn and can tan with olive/gold skin tone
____ Rarely burns with brown skin tone
____ Rarely burns with very deeply pigmented skin tone
List your ethnicity: _____

Do you use Retin-A, Renova, Hydroquinone, Hydroxyl Acid or Retinol/vitamin A , acne prescription derivative products? List products: _____

What areas of concern do you have regarding your skin? Check all that apply

____ Breakouts/acne
____ Blackheads/whiteheads
____ Excessive oil/shine
____ Rosacea
____ Dehydrated skin
____ Broken capillaries
____ Redness/ruddiness
____ Sun spot/liver spot/ brown spot
____ Facial swelling /puffiness
____ Dark under eye circles
____ Uneven skin tone
____ Sun damage
____ Wrinkles/fine lines
____ Dull/dry/ flaky skin
____ Skin laxity
Other :_____
_____

***In the last 2 weeks, have you had treatment such as a facial peel, microdermabrasion, Botox™, Restylane™, Radiesse, or Juvederm? ____ No ____ Yes Please specify: _____**

Female Clients Only:
When was your last menstrual period? _____
Are you pregnant or trying to become pregnant? ____ No ____ Yes

_____No _____Yes I consent to communication for confirmation for future appointments/ promotion/ follow up questions / pictorial exchanges to monitor outcome/ pre and post care instructions.

Preferred method of contact ____Text _____Email ____Text and Email ____ Phone call

____ I understand my financial responsibility for a late cancellation fee of $50 to $100 if a cancel an appointment in less than 24 hours. Late cancellation policy with exceptions available upon request.

____ If I have more than 2 late cancellations I will be ask for a non-refundable deposit to secure my appointment.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from your treatment that may be irreversible. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____

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** **Asterisk** and is **bolded.***