Advanced Medical Spa and Laser Center

PERSONAL INFORMATION

Please complete the following: Date: _____

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ Sate: _____ Zip: _____

Home Telephone: (___)_____ Cell: (_____)_____

Work Phone: (___)_____ Email:_____

This gives us permission to contact you regarding products, treatments, and promotions at all of the above methods: If not, indicate which ones we may use: _____

How did you hear about us? _____

If through internet search, please tell us what source of words you searched:

_____

MEDICAL HISTORY

Please list all allergies (including medications, food, poultry, latex, cosmetics, lidocaine:

_____

Please list all medications, including herbal (esp. St John's Wort) over the counter, you take on a regular basic, or have taken in the last six months:

_____

_____

_____

List all operations (including plastic/laser procedures) Hospitalizations, and any serious illnesses:_____

_____

_____

What are your concerns (please circle any of the following)

Unwanted hair, brown/red spots, wrinkles, lines, sagging skin, acne, blemishes, large pores, age spots, spider veins, other (please list) _____

_____

Have you ever used Accutane? Yes No

If yes, when did you last use it? _____

What topical medications or creams are you currently using? Retin A [ ] others (please list)

_____

Have you ever laser hair removal? Yes No

Have you used any of the following hair removal methods in the last six weeks? Shaving [ ]

Waxing [ ] electrolysis [ ] plucking [ ] tweezing [ ] stinging [ ] depilatories [ ]

Have you had any recent tanning or sun exposure that changed the color of your skin ? Yes __ No __

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No

If yes please describe: _____

Notify your physician (circle drug) if you have used any of the following in the last year (as they are a contraindication to some laser procedures): St. John's wort, Accutane, Tetracycline.

Circle any of the following medications you have taken in the past 6 months (as they may increase hair growth):

Birth control pills, androgens (Rogaine), penicillin, Cyclosporine , Minoxidil, steroids, Haldol, phenytoin, thyroid medications.

For our female clients: Are you pregnant or trying to become pregnant? Yes No

Are you using contraception? Yes No

Are you breastfeeding? Yes No

Have you ever smoked? Yes No How much?_____How long ?_____

Are you still smoking Yes No When did you quit? _____

Who is your personal Physician: _____

Who is your personal dermatologist: _____?

	Yes	No	Dates
Insulin dependent diabetes	___	___	_____
High Blood Pressure	___	___	_____
Frequent Headaches	___	___	_____
Seizure or epilepsy disorder	___	___	_____
Active skin disease/lesions	___	___	_____
Active infection, Staph infection	___	___	_____
Cancer	___	___	_____
Blood clots	___	___	_____
Stroke	___	___	_____
Serious cardiac disease	___	___	_____
Bleeding problems with cuts, surgery	___	___	_____
Jaundice or Hepatitis	___	___	_____
Thyroid Disease	___	___	_____
Dizziness, palpitations, fainting spells	___	___	_____
Cold sores, mouth blisters, fever blisters	___	___	_____
Weight change of 10 pounds in last 6 months	___	___	_____
Psychiatric Disorders	___	___	_____
Arthritis	___	___	_____
Hormone imbalance	___	___	_____
Herpes	___	___	_____
HIV/Aids	___	___	_____
Keloids/scars	___	___	_____
Skin cancer/Melanoma	___	___	_____
Vitiligo, scleroderma, lupus, hives	___	___	_____
Tattoos or permanent makeup	___	___	_____
Other	___	___	_____

Please elaborate on any yes answers

_____

_____

_____

SKIN HISTORY

Which of the following best describes your skin type? (Please circle one skin type number)

1 Always burns, never tans
11 Always burns, sometimes tan
111 Sometimes burns, always tans
1V Rarely burns, always tans
V Brown, moderately pigmented skin (Hispanic)
V1 Black skin

Do you have a history of livedo reticularis, an autoimmune disease, in which the blood vessels are constricted or narrowed resulting in mottled discoloration on large areas of the leg or arms? Yes No

Do you have a history of erythema , persistent skin rash produced by prolonged or repeated exposure of moderately intense heat or infrared irradiation Yes No

List any special skin conditions to your face or body:_____

What skin care products are you currently using?

Face:___soap,___cleanser,___ toner,___ moisturizer, ___masks,___Exfoliator,___eye products,___self-tanner

Body:___soap,___shower gel,___scrubs,___oil,___moisturizer,___depilatory,___products,___self tanner

Have you ever had___chemical peels,___microdermabrasion___,or any resurfacing treatments? In the last three months ?___YES___NO

Do you use ___Accutane,___Retin-A,___Renova,___Adapalene or any other prescription skin products?___Yes___No In the last three months?___Yes___No

Are you currently using any products that contain the following ingredients:___Glycolic acid___lactic acid___exfoliating scrubs___hydroxyl acids___vitamin A (retinol)

Do you ever experience these conditions on your skin:___flakiness___ tightness___obvious dryness

Do you have a tendency to redness?___Yes___No

Do you experience oily shine during the day?___Yes___No

Do you ever experience oily shine during the day?___Yes___No

Do you ever experience skin breakouts? ___Yes___No

Do you ever experience a burning, itching sensation on your skin?___Yes___No

Have you ever had a reaction to any of the following:___Cosmetics___Medicine___iodine__ pollen___food___hydroxyl acids___animals___fragrance___sunscreens___other

What are your skin care goals?

_____

_____

I certify that the preceding history statements are true and correct. I am aware that it is my responsibility to inform my service provider of my current medical or health conditions. It is my responsibility to inform my service provider of any changes to the proceeding information. If I am to enjoy alcohol as part of my experience, I will not hold Skin responsible for any affects/problems that may occur resulting from alcohol consumption after I leave the spa.

Signature: _____ Date: _____

RN/MA Signature: _____ Date: _____

Physician Signature: _____ Date: _____