HEALTH HISTORY

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

PERSONAL INFORMATION

Date: _____

Last Name: _____ First: _____ MLL: ____

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell: _____

(please put in the phone number(s) we can notify you for cancelled or changed appointments)

Email: _____

Date of Birth (month/day/year): _____ Age: _____ Sex: Female / Male

WHERE DID YOU HEAR ABOUT US: (Please be specific)

Magazine ____ Internet ____ Referral ___ Newspaper ____

Other: _____

I AM INTERESTED IN: (Please check all that apply)

O © BOTOX O SKIN REJUVENATION/PHOTOREJUVENATION

O SKIN CARE ADVICE / PRODUCTS O SKIN TIGHTENING

O FILLERS O MICRODERMABRASION O PORTRAIT

O ROSACEA O LIVER SPOTS / AGE SPOTS O FACIAL VEIN TREATMENTS

O ACNE TREATMENTS © LASER LEG VEIN / SPIDER VEIN TREATMENTS

O OTHER, PLEASE SPECIFY: _____

DO YOU USE SUNSCREEN?

O YES, IF YES WHICH SPF # _____ O NO

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

O ALWAYS BURN, NEVER TAN O USUALLY BURN, TAN WITH DIFFICULTY

O ALMOST NEVER BURN, TAN VERY EASILY O RARELY BURN, TAN EASILY

O SOMETIMES BURN, TAN ABOUT AVERAGE O NEVER BURN, ALWAYS TAN

MEDICAL HISTORY (Check appropriate box next to any condition for which you have ever been treated)

O ACNE O ARTHRITIS O AUTOIMUNE DISORDER O BLOOD DISORDERS

O CANCER (OR RADIATION THERAPY) O DIABETES / DIABETIC NEUROPAHGHY O HERPES (OR COLD SORES)

O HIRSUTISM O VITILIGO O KIDNEY DISEASE O MELANOMA O PORT WINE STAIN

O PSORIASIS O PACEMAKER O SHINGLES O SKIN PIGMENTATION

O STEROID OR HORMONAL THERAPY O HORMONAL IMBALANCES

O POLYCYSTIC OVARIUM SYNDROME O KELOID SCARS / OTHER Scars

ADDITIONAL QUESTIONS:

1. ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

_____

2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, MEDICAL PATCHESOR ASA? IF YES, PLEASE SPECIFY.

_____

3. DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

_____

4. HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? IF YES, PLEASE SPECIFY.

_____

5. HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? IF YES, PLEASE SPECIFY.

_____

6. HAVE YOU EVER HAD A CHEMICAL PEEL? IF YES PLEASE SPECIFY.

_____

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7. HAVE YOU HAD ANY LASER TREATMENTS? IF YES, PLEASE SPECIFY.

_____

8. WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

_____

9. DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? IF YES PLEASE SPECIFY.

_____

10. DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

_____

11. DO YOU HAVE A PACEMAKER.

_____

12. HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE) IF YES, PLEASE SPECIFY.

_____

13. DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

_____

14. HAVE YOU EVER HAD GLOD THERAPY? (USED FOR RHEUMATOID ARTHRITIS)

_____

15. ARE YOU CURRENTLY PREGNANT?

_____

16. HAVE YOU HAD RESTYLANE, PERLANE, L, HYLAFORM OR BOTOX INJECTIONS IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

_____

17. DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITES?

_____

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON ALL FORMS ARE ACCURATE, TRUE AND COMPLETE.

Signature: _____ Print Name: _____

Date: _____/_____/_____

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