

Personal Information

Date: _____

Name: _____

Age: _____ Date of Birth: ___/___/___ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

Employer: _____

Occupation: _____

Email Address: _____

(for specials and promotions)

How did you hear of us?: _____

In case of emergency, who should we contact?

_____ Phone: _____

Have you ever received any of the following med-spa services?

- Injectables
- Chemical Peels
- Laser Hair
- Skin Rejuvenation
- Fraxel
- Body Massage
- Body Treatments (wraps/scrubs)

Medical History

Have you ever had (please check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye conditions |
| <input type="checkbox"/> Heart attack or chest pain | <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Delayed or abnormal wound healing | <input type="checkbox"/> Endocrine or hormone disorder |
| <input type="checkbox"/> Heart pacemaker or defibrillator | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Current or recent pregnancy |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Broken Bones in past 2 years |
| <input type="checkbox"/> Wear Contact Lenses | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Other injury in past 2 years |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint Swelling | |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Suffer from Back Pain | |
| <input type="checkbox"/> Varicose Veins | | |

Are you sensitive to touch or pressure in any way? _____

Do you have tension or soreness in a specific area? Please specify _____

Are you receiving chemo or radiation? _____

List any active medical problems you have: _____

List any medications you currently take, include naturopathic or health food supplements: _____

CONTINUED ON BACK

TRANQUILITY

M E D • S P A

Medical History CONTINUED

List any medication allergies you have:

Are you allergic to any metals?: _____ Are you allergic to latex? _____

Do you use any tobacco products?: _____

Dermatologic History

Have you ever had (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic skin condition | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Laser Skin resurfacing |
| <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Herpes simplex or cold sores | <input type="checkbox"/> Chemical Peel |
| <input type="checkbox"/> Keloid or hypertrophic scar | <input type="checkbox"/> Accutane use for acne | <input type="checkbox"/> Botox Injection |
| <input type="checkbox"/> Pigmentation disorder | <input type="checkbox"/> Tetracycline use for acne | <input type="checkbox"/> Injection of collagen or dermal filler |
| <input type="checkbox"/> Recent Waxing or Plucking | <input type="checkbox"/> Electolysis or threading | |
| <input type="checkbox"/> Recent sunburn or tan (including tanning bed) | | |

What is your ethnic background: _____

List any special skin care products you use: _____

Do you use Retinol creams, Retin-A, or other topical preparation? _____

Have you had facial peels, laser or dermabrasion? _____

Have you used facial waxes or depilatories in the last 3 to 4 weeks? _____

How would you like your skin to improve? _____

Surgical History

List any operations you have had (include plastic surgeries):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Authorization for examination and treatment

I, _____, represent to the physician and staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize the taking of photographs. These photographs will be used solely for documentation purposes and will be kept confidential unless otherwise disclosed.

Signature: _____ Date: _____

Parent or Guardian (if Patient is under 18 years of age): _____