NEW PATIENT/MEDICAL HISTORY FORM

Name: ______________________________ Date: ____________________

Address: ____

City: __________________________ State/Zip: _________________________

Please Circle Best Contact Number:

Home Phone: __________________ Cell Phone: ___________________

Work Phone: __________________ Date of Birth: ___________________

SS #: _________________________ Marital Status: **S / M / D / W**

Email: ____

Emergency Contact: _________________________ Phone No. ________________

May we send correspondence to your home address: **Yes / No**

Would you like to be added to our Email Newsletter and Special Offers List: **Yes / No**

How did you hear about us: ____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles:

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

Medications:

List all medications you are currently using or taking, including Vitamins, Herbs, Weight loss Products, Retin A, Glycolic Acid and Accutane: ____

____

Are you currently taking aspirin, Plavix, Coumadin, Blood-thinners, Ibuprofen or any anti-inflammatory drugs? **Yes / No** If so, what products? ____

New Patient/Medical History (continued)

Name: ____

Medical History:

Skin Type – when exposed to the sun **without protection** for about 1 hour you:

____	Always burn, never tan	Type I
____	Almost always burn, sometimes tan	Type II
____	Sometimes burn, sometimes tan	Type III
____	Always tan (American Indian)	Type IV
____	Are Hispanic, Asian, Mediterranean, Middle Eastern	Type V
____	Are Black (African descent)	Type VI

Allergies:

List any **drug, makeup, skin or food allergies** (including drugs taken by mouth, soaps or cleansing creams): ____

____

Are you allergic to **nickel or nickel products**? __________
Are you allergic to **leather, cow (bovine), horse or sheep products**? __________

Surgical History:

Have you had any surgeries on your body? **Yes / No** If so, what and when? ________________________

____

List any Accidents or Injuries: ____

Social History:

Use of Alcohol: Never ____ Rarely ____ Moderate _____ Daily _____
Use of Tobacco: Never ____ Quit ____ (Year ____) Current Packs/day _____

Are you now or have you been under the care of a physician within the last two years? **Yes / No** If *yes, please provide Physician's name and phone number* ____

____

Do you get pigment or brown spots from an injury, insect bite, pimple or cut? **Yes / No**

Are you taking any medications that make you sensitive to sunlight? **Yes / No** If so, what products?
____

Are you using any eye drops or other ocular medications? **Yes / No** If so, what products? ____________
____

Do you chemical tanning solutions? **Yes / No** If so, what products? ______________________________

New Patient/Medical History (continued)

Name: ____

Are you planning a holiday in the sun? **Yes / No** If so, when? ______________________________

Have you ever had any Photo-Rejuvenation sessions? **Yes / No** If so, where and when? _____________

____

Have you recently undergone a Microdermabrasion or chemical peel? **Yes / No** If so, where and when?
____

When were you last exposed to the sun, including tanning booths? ______________________________

Do you have or have you had any of the following conditions? (Answer Yes or No):

____ Abnormal Heart Condition
____ Cold Sores/Fever Blisters
____ Herpes Simplex
____ Hemophilia
____ High or Low Blood Pressure
____ Prolonged Bleeding Condition
____ Circulatory Problems
____ Epilepsy
____ Diabetes
____ Fainting Spells/Dizziness
____ Cataracts
____ Glaucoma
____ Rosacea
____ Mitral Valve Prolapse
____ "Dry Eye"
____ Corneal Abrasions
____ Eye Surgery or Injury
____ Keloid formation or scars
____ Endocrine Disorders
____ Pacemaker or Internal Defibrillator
____ Blepharoplasty (eyelid surgery)
____ Visual Disturbances
____ Cancer of any kind
____ Tumors/Growths/Cysts
____ Chemotherapy/Radiation
____ Asthma
____ Accutane Therapy
____ Hormone Replacement Therapy
____ Implanted Devices
____ Sickle Cell Disease or Trait
____ Are you Pregnant or breast feeding
____ Pregnancy/Hormone related spots
____ Hepatitis
____ Kidney Problems
____ Do you wear contact lenses?
____ Ever had "collagen" injections (e.g. Zyplast or Cosmoplast)
____ HIV
____ Skin Disorders
____ Polycystic Ovarian Disease
____ DVT (Deep Vein Thrombosis)

When was your last eye exam? ____/____/____
When was your last Menstrual Period? ____/____/____

Which of the following best describes your skin? Circle all that apply:

Normal / Dry / Oily / Combination / Acne Prone / Melasma / Rosacea / Eczema / Psoriasis

What skin care product line are you currently using? ____

List skin care products you have had a reaction to: ____

New Patient/Medical History (continued)

Name: ____

Have you ever had any of the following Spa Treatments? (Please circle below):

Facial / Massage / Microdermabrasion / Chemical Peel / Laser

If so, when/what type? ____

Please use this space to discuss your aesthetic concerns or any additional information you would like us to know: ____

____

Signature: ____ Date: ________________

Reviewed By: ____