PATIENT INTAKE FORM

NEWMEDSPA

Name:_____ Today's Date:_____

Address: _____City: _____State:_____Zip:_____

Cell: ( )_____ Home:( )_____

Email:_____ Occupation:_____

Date of Birth:____/_____/_____ Age: _____ Kids ages:_____

Primary Care Physician: _____ Phone Number: ( )_____

Emergency Contact: _____ Phone Number: ( ) _____

Relationship to you? _____

How did you hear about us? _____

What is your main concern that brought you in today? _____

MEDICAL HISTORY: (This information is necessary for your procedure).

Are you using any prescription medications? NO YES, list:_____

_____

Do you take any anti-coagulants (blood thinning) medications? NO YES, list:_____

Are you using any herbal medications? NO YES, list:_____

Do you have any ALLERGIES to any cosmetic ingredients? NO YES, list:_____

Do you have any allergies to medications or food? NO YES, list:_____

Are you pregnant or trying to become pregnant? NO YES

Do you use any hormone replacement therapy? NO YES

Do you smoke? NO YES

Do you use tanning beds? NO YES, How often? _____ Last tan? _____

Do you have any permanent makeup? _____

Have taken Accutane in the last 6 months? NO YES

Are you currently undergoing chemotherapy or radiation? NO YES, for_____

PLEASE CIRCLE ANY HEALTH PROBLEMS PRESENT OR PAST:

Seizures/epilepsy	Heart Problems	PCOS	Thyroid	Hepatitis/HIV
Hormone Problems	High Blood Pressure	Cancer	Asthma	Vasovagal syncope
Autoimmune Disorder	Sarcoidosis	Diabetes	Skin cancer Type:_____	

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PLEASE CIRCLE ANY CHRONIC SKIN DISORDERS:

Psoriasis Dermatitis Eczema Vitiligo Melasma Herpes/Blisters

Keloid Scarring Cystic Acne Other: _____

PLEASE CIRCLE WHICH SKIN CONDITIONS CONCERN YOU THE MOST:

Acne/Breakouts Cystic Acne Acne Scarring Excessive Oil Brown Spots
Sun Damage Uneven Skin Tone Dry Patches Enlarged Pores Upper Lip Lines
Wrinkles Broken Capillaries Unwanted Hair
Other:_____

AS BEST AS YOU CAN PLEASE LIST THE CURRENT PRODUCTS AND BRAND NAMES THAT YOU ARE CURRENTLY USING:

Cleanser:_____Exfoliant:_____Vitamin C:_____
Moisturizer:_____ Eye Cream:_____ Sunscreen:_____
Other:_____

PLEASE CIRCLE ANY OF THE FOLLOWING WRINKLE, FILLER, OR FACIAL TREATMENTS YOU HAVE HAD:

Fillers: Collagen Silicone Restylane Perlane/Lyft Radiesse
Juvederm Voluma Vollure Volbella Sculptra

If so by whom?_____When?_____What area?_____

Muscle Relaxants: Botox Dysport Xeomin

Kybella Other:_____

If so by whom?_____When?_____What area?_____

Have you undergone cosmetic surgery? NO YES, list what area of the body_____

If so by whom?_____When?_____

_____

Printed Name Patient Signature Date