PATIENT HISTORY

To provide you with the most appropriate treatment, please complete the following form. All information is confidential and HIPAA Compliant.

Client Name ______________________________ Mobile Number__________________

Address______________________________ City______________ Zip __________

Email ______________________________________ Birthday _____________

Occupation ____

HOW DID YOU HEAR ABOUT NEW MED SPA? ________________________________

Emergency Contact Name _________________________ Phone Number ______________

MEDICAL HISTORY

Are you currently under the care of a physician for any reason ? Yes No

If Yes, for what? ____

____

Accutane in the last 12 Months	Yes	No	Antibiotics in the last 14 Days	Yes	No
Birth Control Pills or IUD	Yes	No	Anticoagulants, Aspirin, Ibuprofen Use	Yes	No
Retin A, Tretinoin	Yes	No	Hormone Sups /Prescribed Hormones	Yes	No

LIST CURRENT MEDICATIONS ____

____

Are you a smoker? _____ How much are (were) you smoking? ____________ For how long? ________

List Allergies (Medication and Food) ______________________________________

Any Sun Reactions? ____

Circle applicable allergies: Aspirin, Latex, Hydrocortisone, Numbing Agent, Lidocaine, Hydroquinone

Cancer (of any kind) ____

Skin Rashes (Please Explain) ____

Skin Discolorations (Please Explain) ____________________________________

Circle applicable items: Skin Issues/Problems, Fainting, Scars (Severe), Bruise Easily, Slow Healing, Epilepsy/Seizures, Light Headed/Dizzy, Headaches/Migraines, Diabetics, Mouth/Cold Sores, Vision/Eye Problems(i.e.glaucoma,dry eyes), Heart disease, Heart Problems(i.e. irregular heartbeat, pain), Bleeding Disorder/Tendancy, Sinus Issues, High or Low Blood Pressure, Autoimmune disorder (i.e.rheumatoid arthritis), Weakened immune system, HIV, AIDS

Circle any Chronic Conditions: Cystic Acne, Melasma, Vitiligo, Keloid Scarring, Psoriasis Dermatitis, Eczema, Herpes/Blisters

LIST MEDICAL ISSUES NOT LISTED ABOVE ____

TREATMENT HISTORY

Fillers (Restylane, Juvederm, etc.) ____________ If so, when? ______________________________

Neurotoxin (Botox, Dysport etc.) ____________ If so, when? ______________________________

Skin/Light Energy Treatments ____________ If so, when? ______________________________

Chemical Peels ______________________ If so, when? ______________________________

Cosmetic Surgery ________ If so, when? ______________Type? ______________________

Hair Removal ____________ If so, when? ______________Area? ______________________

Sun Exposure/Tanning bed in last week? _________ If so, when? ____________________________

List Current Skin Care Products used regularly: ______________________________________

I'M CONCERNED ABOUT:

____ unwanted facial or body hair
____ broken capillaries on my face
____ fine lines and wrinkles on my face
____ loss of volume in face, cheeks or lips
____ aging skin
____ pigmentation or age spots
____ stretch marks or scars
____ acne/breakouts
____ cystic acne
____ sun damage
____ excessive oil
____ dry patches
____ enlarged pores

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform New Med Spa of my current medical and health conditions and to update this information at subsequent visits. A current history is essential for the provider to execute appropriate treatment procedures.

Guest Signature: ____

Date Signed: ______________________________