New Patient Information and Medical History

Name____________________________________ Sex: M F Date of Birth____________________

Address____________________________________ City_________________ Zip____________ State _______

Phone__________________ Emergency Contact Name & Phone___________________________________

Email____________________________________ How did you hear about us?_______________________

Desired Treatment:	Interested?		Previously Treated		Previous Adverse reaction to treatment
Facial Rejuvenation	Yes	No	Yes	No	
Acne Treatment	Yes	No	Yes	No	
Vein Treatment	Yes	No	Yes	No	
Other					

Yes No Have you taken ACCUTANE in the last 6 months?

Yes No Have you ever used a medication that caused a photosensitivity reaction to sunlight?

Yes No Have you tanned or used any self tanner in the past 4 weeks?

Yes No Do you have sensitive skin?(please describe)____

Yes No Have you ever been diagnosed with a skin condition such as dermatitis or rosacea?________

Yes No Do you smoke? Packs per day _______

Yes No Do you scar easily?

Yes No Have you ever had cold sores (oral herpes) or genital herpes?

Yes No Do you have any lesions, sore, moles or tattoos in the treatment area?

Yes No Do you have a bruising or bleeding disorder?

Yes No Do you take Aspiring, NSAIDS such as Advil, Aleve etc.., Omega III fish oil or flax seed, or other blood thinners?

Yes No Are you pregnant or breast feeding? Or planning to get pregnant in the next 12 months?

Yes No Have you ever been diagnosed or treated for a hormone imbalance?

Yes No Do you now, or have you had a contagious disease? (Hepititis, AIDS, HIV, STD, etc.)______________________________

Yes No Do you have a history of autoimmune disease or any condition that may weaken your immune system?____

Yes No Do you have any neurologic deficits or disorders?_______________________________

Yes No Have you been diagnosed or treated for any emotional or psychiatric problems?____

Yes No Have you ever had an undesirable reaction or outcome to a skin treatment or aesthetic treatment? If yes, to what and what kind of reaction did you have?____

Medical Conditions:	Current Medications:	Past Surgeries and the year:	Allergies:

Products currently using:

Client Signature ____ Date______________________________

Office Use:

Skin Type (circle one)		Hair Color
I-II: Very Fair – Fair	*(burns easily)*	Grey
III: Medium	*(tans gradually)*	Blonde
IV: Moderate Brown	*(Asian/Hispanic)*	Brown
V: Very Dark	*(Dark Hispanic)*	Black Red
VI: Very Dark Brown	*(African-American)*	