Patient Information and Medical History

Ageless Aesthetics MediSpa

Today's Date: _____

Name:_____ Date of Birth:_____

Address_____City_____State_____Zip_____ Occupation:_____

Cell No._____ Home No._____ Work No._____

Referred By_____ Emergency Contact Name: _____ Emergency Contact No. _____

Email_____ May we send you monthly emails regarding our specials? ___ Yes ___ No

Which of the following best describes your skin type? (Please circle only one) **I** Always burns, never tans **II** Always burns, sometimes tans

III Sometimes burns, always tans **IV** Rarely burns, always tans **V** Brown, moderately pigmented skin **VI** Dark Brown skin

Skin Type (Please check only one) ____Normal _____Dry _____Oily _____Combination

MEDICAL HISTORY

Currently under the care of a physician? ____Yes ____No If yes, for what? _____

Currently under the care of a dermatologist? ____Yes ____No If yes, for what? _____

History of erythema abigne, a persistent skin rash produced by prolong or repeated exposure to moderately intense heat or infrared irritation? ___Yes ___No

Do you have, or have you had a history of any of the following medical conditions? (**Please check all that apply)**

____Cancer ____Lymph Node Removal ____Diabetes ____High Blood Pressure ____Cardiac Disorder ____Herpes ____Arthritis ____Cold Sores ____HIV/AIDS ____Keloid Scarring ____Skin lesion/disease ____Seizure Disorder ____Hepatitis ____Hormone Imbalance ____Immune Imbalance ____Thyroid Imbalance ____Blood Clotting Abnormalities ____Any Active Infection

- **Any other health or medical conditions? _____**

Allergic Reactions: (Please check all that apply) ___Food ___Eggs ___ Milk __Latex ___ Aspirin ___Lidocaine ___Numbing Cream ___ Epinephrine (EPI) ____ Vaseline ___Hydrocortisone __Hydroquinone or skin bleaching agents ___Other

- **Oral medications you are presently taking? _____**

Have you ever used Accutane? ___Yes ___No Topical medications or creams you are currently using? ____Retin A ___Others:_____

Herbal supplements used regularly: _____ Do you eat fish regularly? ____ Yes ____ x/week ___ No

What are your main concerns or changes you wish to address? _____

_____

HISTORY

Have you ever had laser hair removal? ____Yes____ No Hair removal methods in the past 6 weeks? ___Shaving ___Wax ___Electro ___Pluck ___Tweeze

Have you used tanning bed or sun exposure that changed skin color? ____Yes ____No Have you used self-tanning lotions or treatments? ____Yes ____No

Do you form thick or raised scars from cuts or burns? ___Yes ___No

Do you have Hyperpigmentation (darkening of the skin) *OR* Hypopigmentation (lightening of the skin) or marks after physical trauma? ___Yes ___No

If yes, please describe_____

FEMALE CLIENTS ONLY

Are you pregnant or trying to become pregnant? __Yes __No Breastfeeding? __Yes __No Birth Control? __Yes ___No Hormones? __Yes ___No

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 the tech, esthetician, therapist, doctor, or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient / Guardian Signature_____ Date _____

Physician Signature _____ Date _____