Ageless Aesthetics MediSpa

Patient Info and Medical History Form

Today's Date: _____

Print Name:_____ Date of Birth:_____

Address_____ City_____ State_____ Zip Code_____

Mobile No._____ Home 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 check 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 Date of last sun exposure to treatment area(s) _____

MEDICAL HISTORY

Currently under the care of a physician? ☐ Yes ☐ No If yes, please explain? _____
Currently under the care of a dermatologist? ☐ Yes ☐ No If yes, please explain? _____
History of erythema abigne, a persistent skin rash produced by prolong or repeated exposure to moderately intense heat or infrared irritation? ☐ Yes ☐ No
Height: _____ Weight: _____ BMI: _____

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 Disease ____Thyroid Imbalance
____Thyroid Carcinoma (Thyroid Cancer) ____Endocrine Neoplasia Syndrome, Type 2 ____Blood Clotting Abnormalities ____Any Active Infection
____Medical Implants ____Hypertrophic Scars ____Poor Wound Healing Any other health or medical conditions? _____

Allergic Reactions: (Please check all that apply)
☐ **Food** ☐ **Milk** ☐ **Aspirin** ☐ **Epinephrine (EPI)** ☐ **Vaseline** ☐ **Hydroquinone or Skin Bleaching Agents**
☐ **Eggs** ☐ **Latex** ☐ **Lidocaine** ☐ **Hydrocortisone** ☐ **Collagen** ☐ **Other** _____
☐ **Topical Hyaluronic Acid** ☐ **Numbing Cream (20% Benzocaine, 10% Lidocaine, 10% Tetracaine)** ☐ **Other** _____

_____
(Initials)
I certify that I have no known allergies or sensitivities to synthetic biomedicals. Should I develop or discover any of the aforementioned at any time, I understand that I am responsible for informing Ageless Aesthetics MediSpa. (Initials are required at the time of medical record update)

Oral medications you are presently taking: _____

Have you ever used Accutane? ☐ Yes ☐ No If yes, please provide the date you last used Accutane?_____
Are you currently using topical medications or creams? ☐ Retin A ☐ Others: _____
Herbal supplements used regularly: _____ Do you eat fish regularly? ☐ Yes ____ x/week ☐ No

Do you smoke tobacco or other recreational drugs? ☐ Yes ____ x/packs week ☐ No   Do you drink alcohol? ☐ Yes ____ x/week ☐ No
What are your main concerns or changes you wish to address? _____

Skin Care Products currently using: _____

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_____

Do you take anticoagulants (i.e. Warfarin (Coumadin), Digoxin (Lanoxin)) for a heart condition?....................................... ☐ Yes ☐ No
Do you take any diuretics or water tablets?.. ☐ Yes ☐ No
If yes, please detail _____

Do you take any steroids? (i.e., Prednisone) .... ☐ Yes ☐ No
If yes, please detail _____

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No   Are you breastfeeding? ☐ Yes ☐ No   Are you on Birth Control? ☐ Yes ☐ No
Receiving Hormone Therapy? ☐ 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 _____

Provider Signature _____ Date _____