



Patient's Name \_\_\_\_\_ M F Age \_\_\_\_\_

Birth-date \_\_\_\_\_ E-mail address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_

(We send auto text reminders)

May we leave a detailed message at this number? \_\_\_\_\_

How did you hear about us? Friend Web Site Facebook

Yellow Pages Newsletter Groupon

Person to notify in case of an emergency:

\_\_\_\_\_ Phone \_\_\_\_\_

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may ask to see your record or get more information by contacting this office.

Our Notice of Privacy Practices describes in more detail how your health information may be used or disclosed and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient (Print first and last name)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient or legally authorized individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of patient

\_\_\_\_\_  
Relationship to Patient

OFFICE STAFF ONLY: A Pro \_\_\_\_\_ Master List \_\_\_\_\_ Nwsltr \_\_\_\_\_



## HEALTH HISTORY

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

### PERSONAL INFORMATION

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Date of Birth (month/day/year): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ Female \_\_\_ Male

I AM INTERESTED IN: (Please check all that apply)

- BOTOX
- SKIN REJUVENATION/PHOTO REJUVENATION
- SKIN CARE ADVICE / PRODUCTS
- LASER HAIR REMOVAL
- FILLERS
- MICRODERMABRASION
- ROSACEA
- LIVER SPOTS / AGE SPOTS
- FACIAL VEIN TREATMENTS
- ACNE TREATMENTS
- LASER LEG VEIN / SPIDER VEIN TREATMENTS
- IPL
- WAXING / BROW TINT \_\_\_\_\_

DO YOU USE SUNSCREEN?  YES, IF YES SPF # \_\_\_\_\_  NO

DO YOU USE SMOKE/CHEW?  YES, IF YES # \_\_\_\_\_  NO

DO YOU TAN?  YES, IF YES OUTSIDE OR IN A TANNING BED?  NO

WHAT IS YOUR SKIN CARE REGIMEN? \_\_\_\_\_

WHAT PRODUCTS DO YOU USE AND HOW OFTEN? \_\_\_\_\_

DO YOU USE: TONER    EXFOLIATOR    MASK    MOISTURIZER    SUNSCREEN    MAKEUP    BRONZER

### MEDICAL HISTORY (Please circle any condition for which you have ever been treated)

- |                                 |                 |                             |
|---------------------------------|-----------------|-----------------------------|
| ACNE                            | HIRSUTISM       | SHINGLES                    |
| ARTHRITIS                       | VITILIGO        | SKIN PIGMENTATION           |
| AUTOIMUNE DISORDER              | KIDNEY DISEASE  | STEROID OR HORMONAL THERAPY |
| BLOOD DISORDERS                 | MELANOMA        | HORMONAL IMBALANCES         |
| CANCER (OR RADIATION THERAPY)   | PORT WINE STAIN | POLYCYSTIC OVARIUM SYNDROME |
| DIABETES / DIABETIC NEUROPAHGHY | PSORIASIS       | KELOID SCARS / OTHER SCARS  |
| HERPES (OR COLD SORES)          | PACEMAKER       |                             |

ADDITIONAL QUESTIONS ON THE NEXT PAGE:

**ADDITIONAL QUESTIONS:**

ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

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ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, MEDICAL PATCHES OR ASA? IF YES, PLEASE SPECIFY.

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DO YOU GET COLD SORES? DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

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HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE, RETIN A OR GLYCOLIC ACID? IF YES, PLEASE SPECIFY.

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HAVE YOU EVER HAD ANY LASER TREATMENTS? IF YES, PLEASE SPECIFY.

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DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

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ARE YOU CURRENTLY PREGNANT AND/OR NURSING?

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HAVE YOU EVER BEEN (OR ARE CURRENTLY BEING TREATED) FOR STAPH INFECTION, MRSA, HIV, OR HEPATITIS?

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DO YOU HAVE ANY METAL IN YOUR BODY? IF YES, PLEASE SPECIFY.

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DO YOU HAVE A PACEMAKER?

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Please sign below to indicate all the information on this for is accurate and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_