



## **PATIENT MEDICAL HISTORY**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Best number to reach you? ☐ Cell Phone ☐ Home Phone ☐ Work Phone

How did you hear about us? \_\_\_\_\_ Referral Name: \_\_\_\_\_

What is the nature of your visit? \_\_\_\_\_

What are your expectations? \_\_\_\_\_

### **PERSONAL MEDICAL HISTORY:**

Please check all the Medical Conditions that apply.

**NONE** ☐

Acne	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Keloids	<input type="checkbox"/>
Bell's Palsy	<input type="checkbox"/>	Permanent Makeup	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>
Blood Clotting Disorder	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>
Cold Sores/Herpes Simplex	<input type="checkbox"/>	Skin Lesions	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Tattoos	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Defibrillator/Pacemaker	<input type="checkbox"/>
Connective Tissue Disorder	<input type="checkbox"/>	Allergy to Lidocaine	<input type="checkbox"/>
Allergy to Latex	<input type="checkbox"/>	Other _____	

Are you Pregnant? ☐ Yes ☐ No ☐ N/A

Are you Nursing? ☐ Yes ☐ No ☐ N/A

Do you exercise? ☐ Yes ☐ No

Do you Smoke? ☐ Yes ☐ No

Please list all medication you are currently taking: (Please include vitamins, herbal supplements, topical creams, etc.)

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List any allergies to medication: ☐ N/A \_\_\_\_\_

List all medical conditions for which you are currently under the care of a physician: ☐ N/A

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Are you currently using:

☐ Aspirin                      ☐ NSAIDS (Motrin, Advil, Aleve)                      ☐ Blood Thinners

### **SKIN HISTORY:**

#### **Have you had:**

Previous reaction / hypersensitivity to Laser Treatments? ☐ Yes ☐ No

Have you been on Accutane in the past 6 months? ☐ Yes ☐ No

#### **Acne:**

Do you have a history of breakouts? ☐ Yes ☐ No

If so, what is the frequency of your breakouts? \_\_\_\_ Frequent \_\_\_\_ Occasional \_\_\_\_ Rarely

Do you experience cystic breakouts? ☐ Yes ☐ No

Do you have any scarring as a result of your acne? ☐ Yes ☐ No

#### **Skin Background:**

Have you had prolonged sun exposure (or tanning bed) in past 3 days? ☐ Yes ☐ No

If so, are you currently sunburned? ☐ Yes ☐ No

Do you use tanning beds? ☐ Yes ☐ No

Are you using chemical tanning solutions? ☐ Yes ☐ No

Do you use sunscreen on a regular basis? ☐ Yes ☐ No

#### **Fitzpatrick I-VI:**

Check one (when exposed to the sun without protection for approximately 1 hour):

☐ (I) Always burns, never tans                      ☐ (IV) Rarely burns, tans more than average

☐ (II) Usually burns, tans less than average                      ☐ (V) Rarely burns, tans profusely

☐ (III) Sometimes mild burn, tans about average ☐ (VI) Never burns, deeply pigmented

#### **Skin Type:**

☐ Caucasian

☐ Asian

☐ Hispanic

Are you tan? ☐ Yes ☐ No

☐ Mediterranean

☐ African American

☐ Other: \_\_\_\_\_

Have you waxed, used depilatories, bleaches or other chemical processes? ☐ Yes ☐ No

How much water do you normally consume daily? \_\_\_\_\_

**Have you had:**

Microdermabrasion ☐ Yes ☐ No

Chemical Peel ☐ Yes ☐ No

Laser Resurfacing ☐ Yes ☐ No

**Do you have:**

Rosacea ☐ Yes ☐ No

Wrinkle Concerns ☐ Yes ☐ No

Scarring Concerns ☐ Yes ☐ No

Sun Damage Concerns ☐ Yes ☐ No

Pigmentation Concerns ☐ Yes ☐ No

Broken Capillary Concerns? ☐ Yes ☐ No

Have you had Botox or other cosmetic injections in the past 6 months? ☐ Yes ☐ No

If yes and less than 3 months, approximate date? \_\_\_\_\_

**Do you use topical ointments?**

☐ Retin-A

☐ Glycolic Acid

☐ Lactic Acid

☐ Hydroquinone

Other: \_\_\_\_\_

What type of skin care products are you using? \_\_\_\_\_

**Please check services of interest:**

☐ Laser Hair Removal (list areas) \_\_\_\_\_

☐ Vein Removal

☐ Fat Reduction Treatment

☐ Laser Genesis, Laser Facials, Acne Treatment

☐ Skin Tightening Treatment

☐ Pigmented Lesions or Brown Spot Removal

☐ Botox, Dysport, Xeomin

☐ Microdermabrasion/Chemical Peels

☐ Dermal Fillers

Other: \_\_\_\_\_

## **AesthetiSpa Policies**

### **Cancellation Policy**

Your appointment time is exclusively reserved for you. Please give 24 hours' notice before your appointment if you need to cancel. Failure to give requested notice more than two (2) times may lead to AesthetiSpa requiring a \$50 credit card deposit to schedule your next appointment.

Patients arriving more than 10 minutes late for an appointment may result in a shortened appointment or may necessitate rescheduling if there is not enough time to complete services safely.

### **Children Policy**

Our goal is to provide a pleasant and relaxing atmosphere for all patients, so we ask that you not bring children to your appointments when possible. Any child under the age of 12 must be attended by an adult who will not be receiving treatment.

We cannot be responsible for the care of unsupervised or unattended children in our reception area.

### **Animals/Pets Policy**

Although we love animals, for the health and safety of our patients and staff we ask that you leave your pets at home during your visit. AesthetiSpa does comply with the American with Disabilities Act (ADA) allowing working service dogs to accompany you during your visit.

\*ADA does not cover emotional support or comfort support animals.

### **Returns/Exchanges**

If you are not satisfied with a retail purchase made at AesthetiSpa, we will gladly offer you a credit which can be used toward future retail purchases. All returns or exchanges must be made within 30 days of purchase.

### **Payment**

We gladly accept Visa, Master Card, American Express, Discover, Care Credit, personal checks and cash. Payment is expected at the time of service.

### **Electronic Devices**

For the comfort of all, please mute cellular phones and laptops. To ensure patient privacy, please refrain from taking any pictures within AesthetiSpa.

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I certify the above medical history information is accurate and correct. I am aware it is my responsibility to inform the Provider of any changes to my medical history. A current medical history is essential to execute appropriate treatment.

I understand AesthetiSpa's policies as outlined and agree to the terms:

I acknowledge I have been provided a copy of AesthetiSpa's HIPAA Notice of Privacy Practices document to read and that a copy will be provided to me if requested.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* Periodically, we send mailings, e-mails or text messages to notify our valued patients of promotions, discounts, and special events. Please let us know if you do not wish to receive this information.

The above patient medical history has been reviewed.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_