



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.)

List any allergies to medication: N/A _____

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

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 then 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: _____