



MED SPA INTAKE FORM

Last Name: _____ First Name: _____
Address: _____ Apt/Floor # _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Sex: Female _____ Male _____
Telephone: Home: _____ Work: _____
Cell: _____ Alternate: _____
Email Address: _____
Family Doctor: _____ Phone: _____
Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____

HEALTH HISTORY

1. List any current or chronic medical illnesses/conditions:

2. Do you have a history of any of the following?

Heart Disease/Conditions _____ Rheumatic Fever _____ Stroke _____ Anemia _____
Rheumatic Fever _____ Hepatitis A _____ B _____ C _____ Kidney Disease _____
High/Low Blood Pressure _____ Diabetes _____

3. Do you take/use any medications, herbal or natural supplements, or topical creams/ointments on a regular or daily basis? Yes _____ No _____

Please List: _____

4. Do you have any allergies to medications, foods, latex, or other substances?

Yes _____ No _____

Please List: _____

5. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy? Yes _____ No _____

6. Do you have a history of herpes I or II in the area to be treated? Yes _____ No _____

7. Do you have a history of keloid scarring? Yes _____ No _____

8. Do you have a history of skin cancer? Yes _____ No _____

9. Are you HIV+? Yes _____ No _____

10. Have you taken anticoagulants in the last 6 months? Yes _____ No _____

11. Do you have any permanent make-up, implants or tattoos? Yes _____ No _____

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12. Have you had any unprotected sun exposure or used tanning creams/beds in the last 4-6 weeks? Yes ___ No ___
 Please specify: _____
13. (For Women) Are you currently using birth control? Yes ___ No ___
14. (For Women) Are you or could you be pregnant? Yes ___ No ___
15. (For Women) Are you trying to get pregnant? Yes ___ No ___
16. (For Women) Are you currently breast feeding? Yes ___ No ___

LIFESTYLE

Occupation: _____

Amount of daily sun exposure: _____

Do you smoke? Yes ___ No ___ If yes, how much/often? _____

Do you consume alcohol? Yes ___ No ___ If yes, how much/often? _____

FACIAL SKIN TYPE

Oily ___ Dry ___ Sensitive ___ Combination ___

Do you have any special skin problems or concerns? _____

Do you use any topical or oral acne medication? Yes ___ No ___

Please specify: _____

Are you currently using or have you used any of the following in the past?
 Retin-A ___ Renova ___ Retinol ___ Vitamin A derivative products ___
 Differin/Adapalene ___ Tretinoin ___

Have you used any of these products in the last 3 months? Yes ___ No ___

Have you used Accutane in the last 6 months? Yes ___ No ___

Types of Skin Care Products Currently Used (Please give brand names)

Cleanser: _____ Toner: _____

Moisturizer: _____ Sunscreen: _____

Eye Cream: _____

Topical Vitamin Products: _____

Please circle which areas you are interested in treating:

FACE NECK CHEST HANDS OTHER _____

How do you want to improve your skin? _____

What areas of concern do you have regarding your skin: (please check all that apply)

- | | | | |
|------------------------|-------|---------------------|-------|
| Breakouts/acne | _____ | Uneven skin tone | _____ |
| Comedones (blackheads) | _____ | Sun damage | _____ |
| Excessive oil/shine | _____ | Wrinkles/fine lines | _____ |
| Rosacea | _____ | Dull/dry skin | _____ |
| Broken capillaries | _____ | Flaky skin | _____ |
| Pigmented lesions | _____ | Scarring | _____ |

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