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. ____________

STREET ____ CITY _________________________________ ST ______ ZIP ____________

HOME PHONE ________________________________ WORK PHONE ____________________________ EMAIL _________________________

WE CONFIRM APPOINTMENTS. DO YOU WANT US TO TELEPHONE [ ] or **SEND AN EMAIL [ ]**

DO YOU WISH TO BE NOTIFIED OF SPECIAL PROMOTIONS OR RECALL APPOINTMENTS? [ ] YES [ ] NO

[ ] YES, BY PHONE AT ____ OR E-MAIL ____

[ ] NO, I DO **NOT** WANT TO BE TELEPHONED OR EMAILED - NEVER EVER!

DATE OF BIRTH (MONTH/DAY/YEAR) ________________________________ AGE _________ SEX [ ] MALE [ ] FEMALE

WHERE DID YOU HEAR ABOUT US? (PLEASE BE SPECIFIC)

[ ] MAGAZINE [ ] INTERNET [ ] REFERRAL ____

[ ] NEWSPAPER [ ] OTHER ____

I AM INTERESTED IN (PLEASE CHECK ALL THAT APPLY):

[ ] BOTOX
[ ] LIPODISSOLVE
[ ] LIVER SPOTS / AGE SPOTS
[ ] THERMAGE
[ ] SKIN REJUVENATION / PHOTOREJUVENATION
[ ] RESTYLANE / PERLANE
[ ] ROSACEA
[ ] VARICOSE VEIN / SPIDER VEIN TREATMENTS
[ ] SKIN CARE ADVICE / PRODUCTS
[ ] MICRODERMABRASION
[ ] ACNE TREATMENTS
[ ] FACIAL VEIN TREATMENTS

[ ] OTHER, PLEASE SPECIFY ____

DO YOU USE SUNSCREEN? [ ] YES IF "YES" SPF ___________ [ ] NO

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

[ ] ALWAYS BURN, NEVER TAN
[ ] USUALLY BURN, TAN WITH DIFFICULTY
[ ] SOMETIMES BURN, TAN ON AVERAGE
[ ] RARELY BURN, TAN EASILY
[ ] ALMOST BURN TAN VERY EASILY
[ ] NEVER BURN, ALWAYS TAN

MEDICAL HISTORY

Check appropriate box next to any condition for which you have ever been treated:

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

PLEASE INITIAL ____

Please see other side.

Additional Questions

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

____

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

____

3. DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

____

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

____

5. HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? IF YES, PLEASE SPECIFY.

____

6. HAVE YOU EVER HAD A CHEMICAL PEEL? IF YES, PLEASE SPECIFY.

____

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

____

8. WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

____

9. DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? IF YES, PLEASE SPECIFY.

____

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

____

11. DO YOU HAVE A PACEMAKER?

____

12. HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)? IF YES, PLEASE SPECIFY.

____

13. DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

____

14. HAVE YOU EVER HAD GOLD THERAPY? (USED FOR RHEUMATOID ARTHRITIS)

____

15. ARE YOU CURRENTLY PREGNANT?

____

16. HAVE YOU HAD RESTYLANE, PERLANE, ARTECOLL, DERMALIVE, DERMADEEP, SILICON, SCULPTRA OR BOTOX INJECTIONS IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

____

17. DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES? TO BE TREATED? IF YES, PLEASE SPECIFY.

____

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

SIGNATURE ____ DATE ____