the
MED SPA
at rejuvenation clinic

Medical History

Name:______________________________ Date:______________
Address:____
Home Phone:__________________ Cell Phone:__________________
Date of Birth:_________________ Referred by:__________________
Emergency Contact:______________________ Phone:______________

What are your main skin concerns?

- ☐ Sun spots
- ☐ Wrinkles
- ☐ Enlarged blood vessels
- ☐ Flushing of the skin
- ☐ Large pores
- ☐ Other:______________________

How many years have you noticed this problem?____________________

Are your present skin problems getting more pronounced? ☐ Yes ☐ No

Have you ever been treated for this problem? ☐ Yes ☐ No

If yes, when?______________________

By what method?____________________________________

Are you currently taking medication for your skin problem? ☐ Yes ☐ No

If yes, which medication?______________________________

Are you pregnant, nursing or planning a pregnancy soon? ☐ Yes ☐ No

Do you have a history of keloid scarring? ☐ Yes ☐ No

Please Check Any Applicable Boxes:

- ☐ Accutane
- ☐ Acne
- ☐ Cancer
- ☐ Contact Lenses
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes Simplex (any form)
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Hyper/Hypo Pigmentation
- ☐ Hyper/Hypo Thyroidism
- ☐ Lupus
- ☐ Melasma
- ☐ Metal Plates/Pins
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Plastic Surgery
- ☐ Psoriasis
- ☐ Retin-A
- ☐ Seborrhea
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Surgeries

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Have you had any allergic reactions to anesthesia? ☐ Yes ☐ No

Do you have any allergies (skin, medication, etc.)? ☐ Yes ☐ No
If yes, please specify:____

Do you take any medication?

☐ Aspirin ☐ Anti-coagulants (blood thinners)
☐ Hormones ☐ Appetite depressant (diet pills)
☐ Thyroid medication ☐ Insulin
☐ Sedatives ☐ Tranquilizers
☐ Cortisone ☐ Other (please specify)_______________________
____

Are you taking any herbal preparations (e.g. St. John's Wort)? ☐ Yes ☐ No
If yes, please list:____

What is your daily consumption of alcohol?______________________________

When were you last exposed to the sun (or a tanning booth) for an extended amount of time?
____

Do you use self tanning lotions? ☐ Yes ☐ No

Have you ever had skin resurfacing, photo rejuvenation or chemical peels? ☐ Yes ☐ No

Have you ever had treatments for pigmented lesions? ☐ Yes ☐ No
Prior treatment (if any):____

Have you ever had Botox or any injectable fillers? ☐ Yes ☐ No
If yes, date of last treatment:_______/______/______

Patient Signature___________________________________ Date:____________________

Patient Signature ___________________________________ Date: ___________________

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