The Med Spa

@

Lake Norman Ob/Gyn

PERSONAL PROFILE & HEALTH HISTORY FORM

Name: _____Home Phone: _____ Date: _____

Address: _____Cell Phone: _____Mobile Carrier_____

City/State/Zip: _____

Date of Birth: ____/____/____ Age: _____ Gender: M ___ F ___ Occupation: _____

Email Address: _____Can we Text and/or Email Confirmations Yes_____No_____

Spouse/Other Email Address for Valentine/Mother's Day, Christmas or Special Events_____

To ensure the safety and effectiveness of your Med Spa treatment program, please complete the medical history questionnaire below.

1. Are you currently pregnant? Yes ____ No ____
2. Are you currently breastfeeding? Yes ____ No ____
3. Since your family background affects your skin and its response to the treatment, please specify by circling your ethnic origin: Caucasian African American Hispanic Asian Native American Middle Eastern Mediterranean Other
4. Which skin areas would you like to consider for treatment?

   _____

5. Medications

   If you are currently taking any medications, including prescription, over-the-counter, vitamins or supplements, please list them:

   _____

6. Allergies

   If you are allergic to any medications, please list them along with your reactions:

   _____

7. Medical History

   Please check all that apply:

☐ Acne	☐ High Blood Pressure	☐ Port-Wine Stain
☐ Bleeding	☐ Implants	☐ Psoriasis
☐ Disorders	☐ Kaposi's Sarcoma	☐ Shingles
☐ Burns or Skin Grafts	☐ Keloid Scars	☐ Skin Cancer
☐ Diabetes	☐ Lupus	☐ Tattoos
☐ Endocrine Disorders	☐ Permanent Makeup	☐ Herpes
☐ Epilepsy	☐ Pregnancy	☐ Vitiligo
☐ Gold Therapy	☐ Ovarian Disease	
☐ Heart Disease		

If the answer to any of the following questions is yes, please provide details in the spaces provided.

1. Are you currently being treated for any medical conditions? Yes No

   Explain: _____

2. Have you used Accutane or any other photosensitive drug in the last 12 months? Yes No

   How recently? _____

3. Do you have any active skin diseases or infection in the area to be treated? Yes No
4. Do you have any skin allergies? Yes No
5. Are you allergic to latex or topical numbing agents? Yes No
6. Are you currently using products which contain Glycolic, Salicylic, Lactic acid, Retin A or AHA? Yes No
7. Have you had a chemical peel or facial within the last week? Yes No
8. What products are you currently using on your skin?

   Describe: _____

9. Have you had any permanent cosmetic tattooing in the area to be treated? Yes No
10. Do you have any metal or other implants? Yes No

    Where? _____

11. Have you had any surgical procedure performed in the area to be treated in the last six months? Yes No
12. Describe: _____
13. Are there any moles in the area to be treated? Yes No
14. Are you currently using or have you used a **tanning bed** or self tanning cream, within the last month? Yes No
15. Have you been excessively exposed to the sun within the last four to six weeks? Yes No
16. Have you waxed or received another form of hair reduction in the last month? Yes No
17. How did you hear about The Med Spa? _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant explained the treatment and answered any questions I had.

Signature of Client: _____ Date: _____

Signature of Consultant: _____ Date: _____

I understand cancellations must be made no later than 24 hours in advance of my appointment time. No shows or cancellations made with less than 24 hours notice for any reason will be charged $25.00.

Signature:_____ Date:_____