The Med Spa AT ACWH

Patient Consent and Information Form

Date_____ Name _____

Address_____ City/State/Zip _____

Date of Birth_____ Age_____ Email_____

Phone(H)_____ (W)_____ (C)_____

List all Allergies_____Are you allergic to Aspirin?_____

List all Medications you are currently taking_____

Are you a smoker_____ Living with a smoker_____

Have you been treated for: (**CIRCLE**) Acne, Skin Disease, Cold Sores, Diabetes, Cancer, High Blood Pressure, Depression?

Are you prone to cold sores? _____ Do you have active cold sores?_____

Are you pregnant?_____ Trying to get pregnant_____ Hormone Therapy_____

Are you currently on the following? (**CIRCLE**)Accutane, Retinin A, Retinol, Hydrocortisone, Glycolic or Blood thinners.

How much water do you drink a day? _____ Do you take Vitamins/Supplements? _____
Do you exercise?_____Do you use tanning beds?_____Your last Sunburn_____

When you go into the sun, do you (**CIRCLE ONE**): Always Burn (I) Usually Burn (II) Sometimes Burn (III) Rarely Burn (IV) Very Rarely Burn (V) Never Burn (VI)

Have you ever been under the treatment plan of: Dermatologist, Plastic Surgeon, Esthetician? If yes, list treatments or surgeries_____

What are you concerns in reference to you face and body? (**CIRCLE ALL THAT APPLY**) Sun Spots, Fine Lines, Wrinkles, Skin Laxity, Acne, White Heads, Black Heads, Dry/Dehydrated Skin, Scarring, Redness, Rosacea, (other) _____

Have you ever experienced the following? (**CIRCLE ALL THAT APPLY)** Facials, Chemical Peels, Microdermabrasion, Laser Hair Removal, Laser Facial Rejuvenation, Botox, Dermal Fillers.

Are you currently on a skincare regime?_____Please list Products _____

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Signature _____ Date _____