T&T MEDSPA HEALTH HISTORY

PERSONAL INFORMATION

DATE: _____

LAST NAME:_____FIRST:_____M.I.:_____

STREET ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE: _____

CELL:_____EMAIL:_____

DATE OF BIRTH (MONTH/DAY/YEAR):_____AGE:_____SEX: ☐ FEMALE ☐ MALE

WHERE DID YOU HEAR ABOUT US: (Please be specific)

INTERNET:_____REFERRAL:_____

ADVERTISEMENT:_____IF SO WHERE:_____OTHER: _____

I AM INTERESTED IN: (Please check all that apply)

- ☐ BOTOX
- ☐ FILLERS
- ☐ ROSACEA
- ☐ ACNE TREATMENTS
- ☐ FINE LINES/WRINKLES
- ☐ SUN DAMAGE
- ☐ CELLULITE REDUCTION
- ☐ SKIN TIGHTENING
- ☐ FAT REDUCTION
- ☐ SKIN CARE ADVICE/PRODUCTS
- ☐ WEIGH LOSS
- ☐ FACIAL/LEG VEIN TREATMENTS
- ☐ HAIR REMOVAL

☐ 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 ABOUT AVERAGE

☐ ALMOST NEVER BURN, TAN VERY EASILY ☐ RARELY BURN, TAN EASILY ☐ NEVER BURN, ALWAYS TAN

MEDICAL HISTORY: (Check the appropriate box next to any condition for which you have ever been treated)

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

ADDITIONAL QUESTIONS:

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

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

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

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

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

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

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

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8 WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

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

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

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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 FILLER OR BOTOX/DYSPORT INJECTIONS IN THE AREA TO BE TREATED?
IF YES, PLEASE SPECIFY.

17 DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES?

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE:_____ DATE: _____

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FACE + BODY AESTHETIC SOLUTIONS