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| --- | --- |
| Name: Date: | Occupation: |
| Address: Phone: | Date of Birth: |
| City: State: Zip Code: | Email: |
| Cell: Phone: Contact me by \_\_Text Cell Phone eMail | Emergency Contact: |
| How did you hear about us: | Referral Name: |
| **General Health** | |
| 1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1 | |
| 2. Are you pregnant or nursing? Yes No | |
| 3. Do you wear contact lenses? Yes No | |
| 4. Do you smoke? Yes No How many cigarettes per day? Drink? Yes No # of drinks per week \_\_\_\_ | |
| 5. Please list any accidents or surgeries in the last 9 months: | |
| 6. Do you have any metal implants, a pacemaker or body piercings? | |
| 7. List the medications you are currently taking: | |
| Prescription | Over the Counter |
|  |  |
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| **Health History** | |
| Heart Condition Lymph Edema Herpes/Shingles High Blood Pressure  Low Blood Pressure | |
| Numbness/Tingling Sinus Problems Allergies Chronic Pain  Varicose Veins | |
| Rashes Jaw Pain/TMJ Blood Clots Constipation  Sprains/Strains | |
| Diabetes Gas/Bloating Headaches Arthritis  Spasms/Cramps | |
| Broken/Fractured Bones Pregnancy ( weeks) Fatigue/Sleep Disorder Depression/Anxiety  Cancer | |
| Other (explain): Undergoing Cancer treatment | |
| **SkIn Care** | |
| 1. Are you under the care of a dermatologist? Yes No | |
| 2. Do you use: Accutane Retin A Renova Adapalene Other prescription skin products \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 3. Have you had a: Chemical Peel Microdermabrasion Botox Other resurfacing treatments | |
| 4. Are you currently using any products that contain: Glycolic Acid Lactic Acid Hydroxy Acid Vitamin A | |
| 5. Do you have any skin sensitivities or irritants | |
| **SkIn MaIntenance** | |
| Products You Use: Soap Cleanser Toner Moisturizer Exfoliator Masque Sunscreen \_\_UVA UVB SPF \_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Skin Type: Oily/Congested Dry/Dehydrated Sensitive/Redness Acne Sunburned | |
| Do you have any of these conditions? Rosacea Acne Shingles HIV Herpes  Eczema Claustrophobia Psoriasis Iodine or Shellfish | |
| Have you been tanning, used spray tan or self tanner in the last 24 hours? Yes No  Are you going or coming from a vacation? Yes No | |
| What are your skin care goals? | |

It is my choice to receive these Services from Ageless Aesthetics. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update the staff Ageless Aesthetics of any changes to my health status.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24hour notice, I agree to pay the missed appointment fee that applies.

Name Date