AGELESS APPEAL MED SPA

Name _____ Date of Birth ____/____/____

Address: _____

City/State/ Zip_____

Home Phone: _____Cell Phone : _____
Can we leave a message at this number? (Y/N) Text Confimation (Y/N)
Email for promotions /Brilliant Distinctions: _____

Occupation:_____
How did you hear about us? Please be specific._____
May we speak with your spouse/significant other/family regarding your treatment?_____ Please advise any additional requests for privacy below:
_____

PERSONAL PROFILE & MEDICAL HISTORY

Complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications.

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Mediterranean ☐ Middle Eastern ☐ Native American ☐ Other:_____

Please list all medications including prescription and over the counter drugs, vitamins, herbs, blood thinners, aspirin, and/or supplements.
_____
_____

Allergic to any medications? (Y/N)_____

Please circle all that apply

Acne, Skin Cancer, other Cancer, Ezema/ Psoriasis, Allergies/Asthma, Scarring/Keloids, Bleeding/Clots, Pacemaker, Currently Pregnant/Breastfeeding, Contact Lenses, Tobacco use, Tanning beds, Accutane, Herpes, Tattoos, Heart Disease, Diabetes, Endrocrine Disorders

If the answer to any of the following questions is yes, please provide details:_____
_____

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PERSONAL PROFILE & MEDICAL HISTORY-Continued

1. Have you used Accutane in the last 6 months?
If yes, how recently? _____

2.What is your current skincare regimen?

AM:_____

PM:_____

3.Do you have any active skin diseases or infections in the area to be treated?
_____

4.Are you allergic to latex, lidocaine, or any lotions? _____

5.Have you had any permanent cosmetic tattooing to the area to be treated?

6.Do you have any metal or other implants? Where?_____

7.Have you had any previous laser treatment or other skin treatments to the area to be treated?
Describe:_____

8.Do you have any history of skin breakouts? _____

9.Do you have any scarring as a result from your breakouts/acne? _____

10.Have you been exposed to the sun within the last four to six weeks? _____

Please circle your concerns

Wrinkles/Fine Lines, Volume Loss, Broken Capillaries, Veins, Undereye darkness eye darkness, Skin texture, Acne Scarring, Skin tightening, Thin Lips, Teeth Staining, Product Education, Massage Therapy, Unwanted hair, Brown/Red pigmenation and tone, Makeup Education,

Print Patient Name:_____

Signature: _____ Date: _____
(Parent or Guardian if patient is under 18)

Office Use

Brilliant Distinctions Account:

Password: