Ageless Appeal
Med Spa

Confidential Client Health History

Name:_____of Birth_____

Address:_____City_____State_____ZIP_____

Home Phone_____ Cell_____

Email:_____ BD Password:_____

Employment_____

Primary Care Physician:_____Phone:_____

Emergency Contact:_____ Phone:_____

Approval to leave a message? Yes/No. Referred by:_____

1) Have you been under the care of a physician, dermatologist or other medical professional within the past Yes/No
   Explain_____
2) Have you had any surgeries, including plastic surgery? Yes/No
   Explain:_____
3) Have you ever had Botox_____Fillers_____Facial Lasers_____
   If so, when?_____
4) List any prescribed medications (including skincare products, acne medication, birth control) that you take regularly?
   _____
5) List any other over the counter medications (including vitamins, herbal supplements, aspirin,etc)_____
   _____
6) ANY KNOWN ALLERGIES? (drugs, chemicals, environmental etc) Yes/No
   List:_____

7) Have you ever been diagnosed with any of the following? (Please check all that apply)

Cancer_____(year/type)	Chemotherapy_____(year)
Headaches_____	Hepatitis_____
High Blood Pressure_____	Fever blisters/cold sores_____
Vitiligo_____	Autoimmune disease (lupus, RA, _____
Thyroid condition_____	HIV/AIDS_____
Tumors/Cysts_____	Metal bone, pins or plates_____
Diabetes_____	Blood clotting abnormalities_____
Heart Problem_____	Psychological treatment_____
Hormone imbalance_____	Skin diseases/skin cancer_____
Asthma/Breathing problems____	Any active infection_____
Keloid scarring_____	Alcoholism_____
Seizure disorder_____	MRSA_____

8) Do you smoke? Yes/No
9) Do you drink alcohol? Yes/No. If so, how much_____
10) Do you form thick or raised scars from cuts/burns? Yes/No
11) Have you ever taken Accutane or any form of Accutane? If so, when?_____
12) Do you use tanning beds, self tanners or have frequent sun exposure?_____

FEMALE CLIENTS ONLY:

13) Are you taking oral contraceptives? Yes/No
14) Are you pregnant or trying to become pregnant? Yes/No
15) Are you currently breast feeding? Yes/No
16) Have you gone through menopause? Yes/No

I understand, read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and or irritation to the skin from treatments received. I am aware that it is my responsibility to inform my provider at Ageless Appeal Med Spa of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Ageless Appeal Med Spa and /or skin care professionals from liability and assume full responsibllity thereof.

REFUND POLICY

All packages and single treatments are non-refundable.

If you no longer wish to proceed with a service or a package of services you've purchased, you will be given the balance on a credit to be used toward other Ageless Appeal services.

Thank you for your understanding and cooperation.

Client/Patient

Signature_____Date_____