MARSHA'S SKIN CARE & MED SPA

Treatment _____

Telemed by _____

Assisted by _____

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PATIENT CONTACT INFORMATION

First Name _____ Last Name _____ Birthday _____ Age _____

Address _____ City _____ State _____ Zip code _____

Cell Phone _____ Home Phone _____ Email _____

Referral _____ Occupation _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ YES ☐ NO
If yes for what? _____
_____

Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer
☐ Frequent Cold Sores
☐ Seizure Disorder
☐ Blood Clotting
☐ Keloid Scarring Active
☐ High Blood Pressure
☐ HIV/AIDS
☐ Hepatitis
☐ Herpes
☐ Infection
☐ Arthritis
☐ Skin Disease/Skin Lesions
☐ Thyroid Imbalance
☐ Hormone Imbalance
☐ Diabetes
☐ Other _____

Do you have any other health problems or medical conditions? Please List: _____

_____

Have you ever had an allergic reaction? (Please check and list any and all that you have had and describe the reaction you experienced)

☐ Vegetable Protein (Nuts, Seeds, Soy)
☐ Animal Protein (Eggs, Meat, Chicken, Poultry, Seafood. Dairy
☐ Aspirin
☐ Lidocaine
☐ Hydroquinone or Skin Bleaching Agents
☐ Hydrocortisone
☐ Other _____
_____
_____
_____
_____

MEDICATIONS

Do Not Leave Any Field Blank. Please Mark As "N/A" If Not Applicable.

What oral prescription medications are you presently taking?

☐ Birth Control (Female Only) ☐ Hormones ☐ Others (It is required that you list them): _____

What antibiotics do you use to treat infections? _____

_____

Do you take any medication for heart conditions? ☐ YES ☐ NO

If yes, please indicate: _____

_____

Are you on any mood altering or anti-depression medication? ☐ YES ☐ NO

If yes, please indicate:

_____

_____

What topical medications or creams are you currently using?

☐ Retin-A/Tretinoin ☐ Hydroquinone ☐ Others (Please list): _____

_____

HISTORY

For Our Female Clients:

Are you pregnant or trying to become pregnant? ☐ YES ☐ NO
Are you breastfeeding? ☐ YES ☐ NO
Are you using contraception? ☐ YES ☐ NO

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

SIGNATURE OF PATIENT/GUARDIAN_____ DATE_____

FOR OFFICE USE ONLY

HEALTH CARE PROFFESSIONAL SIGNATURE _____

PRINT NAME/TITLE _____ DATE_____

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