The Medical Spa

Name_____

Address_____

City_____ State_____ Zip Code_____

Telephone Primary( ) _____ Secondary( ) _____

Date of Birth_____Email Address_____

How did you hear about us?_____

Your Skin

1. What are your skin care concerns? Please check all that apply
   __Oily
   __Acne
   __Acne Scars
   __Sun Damage/Brown Spots
   __Dry
   __Redness/Rosacea
   __Sensitive
   __Wrinkles
   __Laxity
   __Dullness
   __Large Pores
   Other:_____

2. What are your skin care goals?_____
   _____

3. What skin products are you currently using? Please be as specific as possible.
   AM:_____
   PM:_____

4. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?
   □Yes □No *In the last month*? □Yes □No
5. Do you use Accutane, Retin-A or any other prescription skin products?
   □Yes □No *In the last 3 months*? □Yes □No

6. Are you currently using any products that contain the following ingredients?
   □Glycolic acid □Lactic Acid □Any exfoliating scrubs □Any Hydroxy Acid product □Vitamin A derivatives (i.e., retinol) □Benzoyl Peroxide □ Salicylic Acid
7. What SPF sunscreen do you use on your face? _____ Body? _____
8. Do you sunbathe or use tanning beds? □Yes □No
   If yes, how many times per week? _____
9. Do you burn easily in moderate sunlight? □Yes □No
10. Have you ever had a reaction to any of the following?
    □Cosmetics □Medicine □Iodine □Pollen □Food □Hydroxy acids □Animals □Fragrances □Sunscreens □Other_____
11. Are you allergic to Aspirin? □Yes □ No
12. Are you lactose intolerant? □Yes □ No

Female clients

13. Are you taking oral contraceptives? □Yes □ No
14. Are you pregnant or trying to become pregnant? □Yes □ No
15. Are you lactating? □Yes □ No
16. Are you post-menopausal? □Yes □ No

I confirm (to the best of my knowledge) that all of the answers I have given are correct and I have not withheld any information that may be relevant to my treatment.

Client signature _____ Date _____