SIGNATURE
MEDICAL AESTHETICS

Name:		Date:	Occupation:	
Address:		Phone:	Date of Birth:	
City:	State:	Zip Code:	Email:	
Cell: Phone:	Contact me by _Text Cell		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?
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

Health History

Heart Condition	Lymph Edema	Herpes/Shingles	High Blood Pressure
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain
Rashes	Jaw Pain/TMJ	Blood Clots	Constipation
Diabetes	Gas/Bloating	Headaches	Arthritis
Broken/Fractured Bones	Pregnancy (___weeks)	Fatigue/Sleep Disorder	Depression/Anxiety

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

ProductsYouUse:	SoapCleanser	TonerMoisturizer	Exfoliator	Masque	
Skin Type:Oily/Congested	Dry/Dehydrated	Sensitive/Redness	Acne	Sunburned	
Eczema	Claustrophobia	Psoriasis	IodineorShellfish		
Haveyoubeen tanning inthelast24hours? Yes	No	Are you going or coming from a vacation? Yes	No		
What areyourskin caregoals?					

Itismychoicetoreceive these Services from Signature Medical Spa.Ihavecompleted thisform tothebestofmyknowledge.Ihavestatedallmedicalconditionsthatlamawareofandlwillupdate the staff at Signature Medical Spaofanychangestomy healthstatus.Iunderstandthat the staff at Signature Medical Spadonotdiagnoseillness, disease, orphysicalormentaldisorders,nordotheyprescribemedicaltreatments,pharmaceuticals,orperformspinal manipulations.Iacknowledgethatthese treatmentsarenotasubstituteformedicalexaminationordiagnosis,andthatisrecommendedIseeaprimaryhealthcare providerforthatservice.Ifiam unable tomakeascheduledappointment,Iagreetocanceltheappointment24hoursinadvance byphone, unlessIhaveanemergency.Inthiscaselwillcall ASAPtoreschedule myappointment.Ifimiss ascheduledappointmentwithoutgiving24hournotice,Iagreetopaythemissedappointmentfeethatapplies .

Name

Date