body TONIC | Rx
laser + skincare + med spa

PATIENT INFORMATION

First Name:_____ Last Name: _____

Age: _____ Date of Birth: ___/____/_____ Sex: FEMALE MALE

Email: _____

Cell Ph#:_____ Alternate Ph# _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ Pharmacy/Ph#: _____

Contact person in case of emergency: _____

Reason for today's initial visit: _____

What other treatments may interest you in the future?

( )Fillers ( )Botox ( )Kybella ( )Sculptra ( )Laser Skin Resurfacing ( )Photofacials ( )Skin Tightening ( )Microblading ( )Microneedling ( )Hair Restoration ( )Sclerotherapy

Referral Source: ( )Yelp ( )Website ( )Google ( )Instagram ( )Facebook

( )Friend/ Family _____ ( )Other _____

PATIENT MEDICAL HISTORY

Do you have a history of erythema abigne, which is the persistent skin rash caused by prolonged or repeated exposure to moderately intense heat or infrared irritation? ( )Yes ( )No

Have you ever used any of the following? ( )Retin A ( )Accutane ( )Hydroquinone ( )Renova ( )AHA/BHA

Are you currently using a retinoid? ( )Yes ( )No

What is your current skin care regime?

Cleanser: _____ Toner: _____ Moisturizer: _____

Sunscreen: _____ Other prescriptions gels, creams, etc: _____

List all hospitalizations or surgeries: _____

_____

body TONIC | Rx
laser + skincare + med spa

Do you have now, or have you ever had diseases of, or conditions of (Please check YES or NO):

	YES	NO		YES	NO
High Blood Pressure			HIV/AIDS		
Chest Pain			Diabetes		
Heart Attack			Thyroid		
Heart Murmur			Kidney		
Irregular Heartbeat			Bladder		
Pacemaker			Stomach		
Phlebitis			Bowel		
Glaucoma			Hepatitis (Any kind)		
Arthritis/Joint Deformity			Syphilis		
Convulsions/Epilepsy/Fainting			Herpes		
Anxiety					

List all medications you are currently taking, including prescription/non-prescription drugs, vitamins, daily aspirin, fish oil, vitamins, herbs, and any other dietary supplement:

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ( )NO ( )YES, If yes, please list

_____

_____

Allergy to latex? ( )Y ( )N Allergy to lidocaine? ( )Y ( )N Allergy to sutures? ( )Y ( )N
Do you have any metal implants? ( )Y ( )N
Have you ever had dental anesthesia (Novocain)? ( )Y ( )N Any bad reaction? ( )Y ( )N
Have you ever had local anesthesia (Xylocaine, Marcaine)? ( )Y ( )N Any bad reaction? ( )Y ( )N
WOMEN: Are you pregnant, thinking of getting pregnant, or breastfeeding? _____
Last menstrual period? _____ ( )Regular ( )Irregular
Do you ever get cold sores or fever blisters? ( )Y ( )N
Do you bleed easily? ( )Y ( )N
Do you smoke? ( )Y ( )N If yes, for how long? _____ How many per day? _____
Do you use alcohol? ( )Never ( )Social ( )Daily
Do you use recreational, illicit or IV drugs? ( )Y ( )N If yes, what? _____ How often? _____
When you are exposed to sun, do you: ( )Tan only ( )Tan and burn ( )Burn
Have you ever had skin cancer? ( )Y ( )N
Has anyone in your family had skin cancer? ( )Y ( )N If yes, who? _____
Do you have a history of any specific skin, hair or nail diseases? ( )Y ( )N List: _____
List any other diseases or conditions we should know about: _____
List all cosmetic procedures you've had: _____
Do you scar easily or excessively? ( )Y ( )N Do you form keloid (thick, raised) scars?( )Y ( )N
Do you have any artificial joints? ( )Y ( )N
Are you currently on any mood altering or anti-depressant medication? ( )Y ( )N

**I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, aesthetician, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute proper treatment procedures.*

Patient Signature/Date: _____
Witness/Date: _____