Patient Medical History

Date: ____/_____/____ Name: _____Date of Birth: _____/_____/_____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

E-mail address: _____

Single: ○No ○Yes Married: ○No ○Yes If yes, anniversary date: _____

Occupation: _____ Emergency Contact: _____

Does your job require that you work outdoors? ○No ○Yes

Referred by: _____

What procedures are you interested in? Check **all** that apply

○Laser Hair Removal ○IPL Photofacial (Brown Spots/Redness) ○Microdermabrasion ○Skincare ○Massage
○Microneedling/PRP ○Botox ○Dermal Filler ○Teeth Whitening ○Cellulite ○Acne ○Body Contouring
○Tattoo Removal ○Skin Resurfacing ○Wrinkles/Fine Lines ○Skin Tightening ○Chemical Peel
○Dermaplaning ○Vaginal/Penile Rejuvenation ○Hair Restoration ○Weight Loss Management/Fat Loss
○Wellness Injections ○Carbon Laser Peel ○Intimate Chemical Peel ○PDO Thread Lift ○PRP Injections

What would you like to achieve from your treatments?_____

_____

List all medications and supplements:_____

_____

Any known allergies to foods, medications, substances?_____

_____

Do you smoke, drink alcohol or use recreational drugs? No ___Yes, Explain_____

Have you had any previous surgeries? No ___Yes, Explain_____

Please check any condition that you currently have or have had in the past:

○Heart Problem ○Diabetic ○HIV/AIDS ○Lupus ○Hepatitis ○Auto Immune Disease ○Bruise Easily
○Poor Wound Healing ○Claustrophobic ○Asthma ○Eczema ○Psoriasis ○Vitiligo ○Keloid Scar
○Pacemaker ○Metal Implant ○Seizure ○Epilepsy ○Anxiety ○Depression ○Hyper Thyroid ○PCOS
○Excessive Hair Growth ○Excessive Hair Loss ○Permanent Makeup ○Tattoo ○MS ○ALS ○Bell's Palsy
○Cold Sores/Herpes Simplex ○Shingles ○High Blood Pressure ○Varicose Veins ○Scleroderma ○Hernia
○Bleeding/Clotting Disorder ○Hyper/Hypo - Pigmentation ○Other_____ ○None

Client Initial_____

Your Skin Care

1) Have you ever had a facial treatment before? ○No ○Yes, when? _____

2) Have you ever had a body spa treatment before?○No ○Yes List:_____

3) Which of the following best describes your skin when exposed to the sun for 30 minutes & no SPF:

○ Always burns easily, never tans with very pale skin tone
○ Always burns, tans with a hint of color with very pale skin tone
○ Burns initially, tans gradually with light skin tone
○ Can burn and can tan with olive/gold skin tone
○ Rarely burns with brown skin tone
○ Rarely burns with very deeply pigmented skin tone

Your ethnicity: _____

4) Do you have any special skin problems or concerns pertaining to your face or body? ○Yes ○No

If yes, please specify: _____

5) Have you ever had chemical peels, laser treatments or microdermabrasion? ○No ○Yes

In the last month? ○No ○Yes If yes, please describe: _____

6) Do you use Retin-A, Renova, Hydroquinone, Hydroxyl Acid or Retinol/Vitamin A derivative products?

○No ○Yes If yes, please describe: _____

_____

7) Have you used any of the above products in the last 3 months? ○No ○Yes

8) Have you used an acne medication? ○No ○Yes, when? _____

What type? _____

9) What skin care products are you currently using? (List brand)_____

_____

10) Have you recently used any self-tanning lotions, creams or treatments ○No ○Yes

Please specify: _____

11) Have you used any of the following hair removal methods in the past 4 weeks? ○No ○Yes

If yes, where on your body?_____

Please circle all that apply:

○Shaving ○Waxing ○Electrolysis ○Tweezing ○Threading ○Depilatories ○Laser

Client Initial_____

12) What areas of concern do you have regarding your skin? Check all that apply

○Breakouts/Acne ○Blackheads/Whiteheads ○Excessive Oil/Shine ○Rosacea ○Dehydrated Skin
○Broken Capillaries ○Redness/Ruddiness ○Sun Spots/Liver Spots/Brown Spots ○Puffiness
○Dark Circles ○Uneven Skin Tone ○Sun Damage ○Wrinkles/Fine Lines ○Dull/Dry Skin ○Flaky Skin
Other _____

13) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)
If yes, please explain: _____

○Cosmetics ○Medicine ○Food ○Animals ○Sunscreens ○Iodine ○Pollen ○AHA
○Fragrance ○Salicylic Acid ○Shellfish ○Latex ○Drugs ○Sun ○Numbing Agents

14) What SPF do you use on your face? _____ How often/when? _____

15) What SPF do you use on your body? _____ How often/when? _____

16) In the last 2 weeks, have you had any tanning bed or sun exposure?

Did you tan or burn? ○No ○Yes

Please specify: _____

17) In the last 2 weeks, have you had injections such as Botox™, Restylane™ or Collagen? ○No ○Yes

Please specify: _____

Female Clients Only:

18) Are you taking oral contraceptives? ○No ○Yes

Please specify: _____

19) Any recent changes to or from your contraceptive treatment? ○No ○Yes If so, what and when:_____
_____

20) Are you pregnant or trying to become pregnant? ○No ○Yes

21) Are you lactating? ○No ○Yes

22) Any menopause problems? ○No ○Yes

Please specify: _____

23) Are you undergoing any hormone replacement therapy? ○No ○Yes

Please specify: _____

Client Initial_____

Male Clients Only:

24) What is your current shaving system? ○Wet Shave ○Electric

25) Do you experience irritation from shaving? ○No ○Yes Ingrown hairs? ○No ○Yes

Future Appointments/Contact:

May we call home, work or cell phone number to confirm future appointments?

○No ○Yes Preferred method of contact:

May we contact you via email and SMS to confirm appointments and promotions? ○No ○Yes

Photography Release

I understand that before and after photographs of my treatment area are required for insurance, treatment documentation and training purposes.

Any specific photo use instructions? _____

*I understand that my photos may be used for advertising use, my photos will no longer be protected by federal privacy laws and I hereby release Newman Initiatives, LLC DBA Newman & Company, its affiliates, successors, owners, employees and assignees from any claim demand, cause, action or proceeding of whatever nature arising out of publication and distribution of said photos.

Please Initial _____

I understand, have 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 complications from your treatment that may be irreversible. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

Client Name (printed): _____

Client Signature: _____ Date: _____