

MedSpa 1064
Suites at Somerset Square
140 Glastonbury Blvd.
Glastonbury, CT 06033
860.657.1064



Welcome to MedSpa 1064, Connecticut's Premier Center for Cosmetic Laser Medicine

This form is to introduce you to our facility and to help us better serve you.
Please fill out the following:

Name _____ Date of Birth ____/____/____

Address: _____

City/State/ Zip _____

Home Phone # () _____ Cell Phone # () _____

Which phone # may we use to contact you? _____

Can we leave a message at this number? _____

Email for promotions and newsletter: _____

Occupation: _____

How did you hear about us? Please be specific. _____

May we speak with your spouse/significant other/family regarding your treatment? _____

Please advise any additional requests for privacy below:

Your treatments at Medspa 1064 are reserved exclusively for you. Please kindly give us 24 hours notice before your scheduled appointment if you need to cancel or reschedule to avoid being charged a \$50.00 facility fee.

Please keep your belongings with you, as Medspa 1064 is not responsible for lost or stolen articles.

Signature: _____

(Client/Parent or Guardian if patient is under 18)

Date

Please print name if you are the Parent/Guardian _____



PERSONAL PROFILE & MEDICAL HISTORY

Females: Are you pregnant? Yes No Are you breastfeeding? Yes No

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:

- African American Asian Caucasian Hispanic
- Mediterranean Middle Eastern Native American
- Other: _____

Complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications.

Please list **all medications** including prescription and over the counter drugs, vitamins, herbs, *blood thinners, aspirin*, and/or supplements.

Allergic to any medications? No Yes, Please list: _____

Please check all that apply

- Acne High Blood Pressure Precocious Puberty
- Bleeding Disorders Hirsutism Psoriasis
- Burns/Skin Grafts Hormone Replacement Rx Rosacea
- Claustrophobia Cold Sores Implants
- Seizures Diabetes Kaposi's Sarcoma
- Shingles Eczema Keloid Scars
- Skin Cancer Endocrine Disorders Lupus Erythematosus
- Tattoos Epidermolysis Bullosa Thyroid Disease
- Gold Therapy Polycystic Ovary Disease Vitiligo
- Heart Disease Port-Wine Stain Permanent Makeup
- Herpes Hepatitis HIV/AIDS
- Other: _____

Surgeries: _____

Please list any other pertinent medical information.

If the answer to any of the following questions is yes, please provide details: _____

PERSONAL PROFILE & MEDICAL HISTORY-Continued

- | | | | |
|-----|---|-----|----|
| 1. | Have you used Accutane in the last 6 months? | Yes | No |
| a. | If yes, how recently? _____ | | |
| 2. | <u>Are you currently using glycolic acid or Retin A?</u> | Yes | No |
| 3. | What products are you currently using on your skin? | | |
| a. | Describe: _____ | | |
| 4. | <u>Do you have any active skin diseases or infections in the area to be treated?</u> | Yes | No |
| 5. | <u>Are you allergic to latex, lidocaine, or any lotions?</u> | Yes | No |
| 6. | <u>Have you had any permanent cosmetic tattooing to the area to be treated?</u> | Yes | No |
| 7. | <u>Do you have any metal or other implants? Where?</u> | Yes | No |
| 8. | Have you had any previous laser treatment or other skin treatments to the area to be treated? Describe: _____ | Yes | No |
| 9. | <u>Are there any moles with hair in the area to be treated?</u> | Yes | No |
| 10. | <u>Do you have any history of skin breakouts?</u> | Yes | No |
| 11. | <u>Do you have any scarring as a result from your breakouts/acne?</u> | Yes | No |
| 12. | <u>Have you been exposed to the sun within the last four to six weeks?</u> | Yes | No |
| a. | If yes, approximate date of last exposure _____ / _____ / _____ | | |
| 13. | <u>Do you use tanning beds. If yes, date of last use _____ / _____ / _____</u> | Yes | No |
| 14. | <u>Do you burn easily in moderate sunlight?</u> | Yes | No |
| 15. | <u>Do you blush easily when nervous?</u> | Yes | No |
| 16. | <u>Do you frequently experience flakiness, tightness or dryness?</u> | Yes | No |
| 17. | <u>Do you use sunscreen on a regular basis?</u> | Yes | No |
| 18. | <u>Have you waxed, used depilatories, bleaches or other chemical processes?</u> | Yes | No |
| 19. | How much water do you normally consume daily? _____ | | |
| 20. | <u>Do you smoke?</u> | Yes | No |
| 21. | <u>Do you wear contact lenses?</u> | Yes | No |
| 22. | <u>Do you exercise?</u> | Yes | No |
| 23. | <u>Have you had microdermabrasion?</u> | Yes | No |
| 24. | <u>Have you had any chemical peels?</u> | Yes | No |
| 25. | <u>Have you had laser resurfacing?</u> | Yes | No |
| 26. | <u>Do you have wrinkle concerns?</u> | Yes | No |
| 27. | <u>Do you have scarring concerns?</u> | Yes | No |
| 28. | <u>Do you have sun damage concerns?</u> | Yes | No |
| 29. | <u>Do you have pigmentation concerns?</u> | Yes | No |
| 30. | <u>Do you have broken capillary concerns?</u> | Yes | No |

What services are you most interested in?

Name of your family doctor: _____ Phone #: (____) _____

I confirm that the answers to the questionnaire are true and correct.

Print Patient Name: _____

Signature: _____ Date: _____

(Parent or Guardian if patient is under 18)