

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 # () _____

Occupation _____

Email _____

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

Which phone # may we use to contact you? _____

Can we leave a message at this number? _____

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

May we contact you via Email? _____

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.**

Print Patient Name: _____

Signature of Client: _____ Date _____
(Client/Parent or Guardian if patient is under 18)

Please print name if you are the Parent/Guardian _____

Witness: _____ Date: _____

PERSONAL PROFILE & MEDICAL HISTORY-Continued

1. Have you used Accutane in the last 6 months? Yes No
a. If yes, how recently? _____
2. Are you currently using glycolic acid or Retin A? Yes No
3. What products are you currently using on your skin?
a. Describe: _____
4. Do you have any active skin diseases or infections in the area to be treated? Yes No
5. Are you allergic to latex, lidocaine, or any lotions? Yes No
6. Have you had any permanent cosmetic tattooing to the area to be treated? Yes No
7. Do you have any metal or other implants? Where? Yes No
8. Have you had any previous laser treatment or other skin treatments to the area to be treated? Describe: _____ Yes No
9. Are there any moles with hair in the area to be treated? Yes No
10. Do you have any history of skin breakouts? Yes No
11. Do you have any scarring as a result from your breakouts/acne? Yes No
12. Have you been exposed to the sun within the last four to six weeks? Yes No
a. If yes, approximate date of last exposure _____ / _____ / _____
13. Do you use tanning beds. If yes, date of last use _____ / _____ / _____ Yes No
14. Do you burn easily in moderate sunlight? Yes No
15. Do you blush easily when nervous? Yes No
16. Do you frequently experience flakiness, tightness or dryness? Yes No
17. Do you use sunscreen on a regular basis? Yes No
18. Have you waxed, used depilatories, bleaches or other chemical processes? Yes No
19. How much water do you normally consume daily? _____
20. Do you smoke? Yes No
21. Do you wear contact lenses? Yes No
22. Do you exercise? Yes No
23. Have you had microdermabrasion? Yes No
24. Have you had any chemical peels? Yes No
25. Have you had laser resurfacing? Yes No
26. Do you have wrinkle concerns? Yes No
27. Do you have scarring concerns? Yes No
28. Do you have sun damage concerns? Yes No
29. Do you have pigmentation concerns? Yes No
30. Do you have broken capillary concerns? 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. I also confirm that the consultant has clarified any questions I did not understand.

Print Patient Name: _____

Signature: _____ Date: _____
(Parent or Guardian if patient is under 18)

Witness: _____ Date: _____