gentle touch
medical aesthetics • wellness spa

AESTHETIC HEALTH INFORMATION QUESTIONNAIRE

Name: _____ Date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Home: _____Cell: _____ Work: _____

Email: _____DOB: _____

How did you hear about us? _____

Would you like to receive email notifications about our upcoming specials? Yes_____ No_____

Emergency Contact: _____Phone:_____

HEALTH HISTORY

Medication (prescription & over the counter supplements): _____

_____

_____

_____

Surgeries/Dates (cosmetic & medical): _____

_____

Allergies (latex, iodine, etc.): _____

Have a history of?
(Check all that apply)

- ☐ Heart Disease
- ☐ Cold Sores
- ☐ Neuro-muscular
- ☐ Excessive Bleeding
- ☐ Liver Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Auto-immune Disease
- ☐ Seizures
- ☐ Migraines
- ☐ Fainting
- ☐ Other_____

Are you? Pregnant _____ Nursing _____
Do you? Smoke _____ Drink Alcohol _____ Amount per day _____

Name: _____ Date: _____

WHAT MEDICAL AESTHETIC PROCEDURES ARE YOU INTERESTED IN?

(Check all that apply)

- ☐ Botox
- ☐ Dermal Fillers (Juvederm XC, Radiesse)
- ☐ Laser Skin Resurfacing
- ☐ Laser Scar Resurfacing
- ☐ IPL Photo Rejuvenation
- ☐ Laser Hair Removal
- ☐ Acne &/or Surgical Scars
- ☐ Facial Vessels/Rosaecea
- ☐ Sun/Age Spots
- ☐ Spider Vein Treatments (Legs)
- ☐ Stretch Marks
- ☐ Melasma

Have you ever had/are currently using:

Retin-A Renova, any retinoic acid	Y	N
Accutane	Y	N
Prescription acne medication	Y	N
Birth control pills/patch	Y	N
Steroids	Y	N
Tanning (last 2 weeks)	Y	N

Previous Cosmetic Facial Treatments:

Botox	Y	N	Date: _____
Dermal Fillers	Y	N	Date: _____
Laser treatments	Y	N	Date: _____
Microdermabrasion	Y	N	Date: _____
Chemical peel	Y	N	Date: _____
Facial Surgery	Y	N	Date: _____

What skin care products are you currently using? _____

_____

Are you concerned about aging eye lashes? Y N

Are you currently using sunscreen? Y N

The above information is true and accurate to the best of my knowledge

_____

Patient Signature Date