NEW PATIENT QUESTIONNAIRE

Patient Name (please print legibly): _____ **Date:** _____

Date of Birth: _____ **Gender: F / M** **Occupation:** _____

Address: Street _____ **City:** _____

State: _____ **Zip Code:** _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____

Pharmacy Phone: _____

Email address (please print legibly): _____

Referred by: **Physician ☐** **Patient ☐** **Friend ☐** **TV ad ☐** **NP ad ☐** **Other ☐**

Please specify: _____

IS IT OK FOR THE DOCTOR OR THE MEDSPA STAFF TO CALL YOU? YES☐ NO☐

WHICH NUMBER CAN WE USE? WORK ☐ HOME ☐ CELL ☐

It is extremely important that we are aware of all of your medical conditions and of the medications and supplements/vitamins that you take. It will help us give you the best aesthetic skin care, and it can help us avoid any potential interactions between your medications and the treatments that we may recommend. Please provide all of the following information and be as complete as you possibly can.

Age: _____ **Height:** _____ **Weight:** _____

Please circle all of the following **medical conditions** you now have or have had in the past:
bleeding tendency / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / high blood pressure / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / rheumatoid arthritis / scleroderma / lupus / porphyria / depression/ anxiety/ mental illness / drug or alcohol addiction / hepatitis B / hepatitis C / HIV / cancer/ any other serious illness or injury / hernias/ Raynaud's/ **None** of the above
Other (please list):
Give Details of any Circled Items (use back of page if necessary)

List all **surgeries** that you have had (include plastic surgery): (use back of page if necessary)
Date:

Vibrance MedSpa Policies

We understand that there are times when you need to cancel your scheduled appointment due to emergencies and other obligations. However, due to the block of time our doctors/skin care specialists provide for all appointments we ask that you provide us with at least 48 hours notice should you have to cancel your appointment.

When you do not call to cancel or reschedule your appointment you may be preventing someone else who wants to come in for a treatment or an appointment.
Clients who NO SHOW or cancel less than 48 hours in advance of their scheduled appointment may be charged a $50.00 fee.

We want to maintain a relaxing environment for all of our clients as well as ensure the safety of your children. For this reason there are NO CHILDREN allowed in the spa for any reason. Due to our policy, if you are to arrive with your child we will have to reschedule your appointment.

Please note that in case of inclement weather the spa will be closed. Each client will receive a phone call to notify you of closure and your appointment will be rescheduled.

Thank you for your cooperation.
Sincerely,
Vibrance MedSpa
I understand the terms of this form and am aware that I am financially responsible for charges incurred for cancellations and no shows.
Print Name:_____
Signature: _____
Date: _____

Please list all **medications** which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, weight loss medications, Coumadin or any blood thinning medication, prescription eye drops, steroids) Use back of page if necessary.

(Both legal and non legal to help us avoid any potential interactions with your treatment)

Medication(s) Amount Frequency

Please list all Naturopathic or Health Food Supplements:

List all **ALLERGIES** including **LATEX** _____ NONE

Are you a smoker? YES/NO Ex-smoker: YES/NO

Do you have a pacemaker? YES/NO Internal defibrillator? YES/NO Chemo port? YES/NO

Have you had chemotherapy or radiation? YES / NO If so, when? _____

How much alcohol do you drink? _____ Caffeine Use: _____

Is there any possibility that you may be pregnant at this time? YES / NO / not applicable

Are you trying to get pregnant? YES/NO/not applicable Are you taking hormones? YES/NO

Do you have a history of herpes simplex virus (cold sores)? YES/NO Last outbreak?_____

Are you allergic to shellfish? YES/NO Are you allergic to aspirin? YES/NO

Have you ever been on Accutane? _____ When? _____

Do you have a history of atypical moles, melanoma or skin cancer in yourself or family? Yes/No

Have you or anyone in your family ever had unusual reactions to topical anesthetics (substances placed on the skin to numb the skin)? YES / NO

Do you have (circle): loose or chipped teeth / caps / dentures / contact lenses / none

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status.

Patient Signature: _____ Date: _____

Authorization for Examination and Treatment

I represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize the clinical staff to take my medical history and perform any necessary examinations. I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. **These**

photographs will be used solely for documentation purposes and will be kept confidential unless otherwise disclosed.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP: (circle one) PATIENT/ SPOUSE/ PARENT/ GUARDIAN

SKIN CARE HISTORY

Do you have any history of chronic acne? _____

Do you use Retinol creams, Retin – A, or other topical prescription medication? _____Do you have a history of developing keloids (thickened, raised scars)? _____

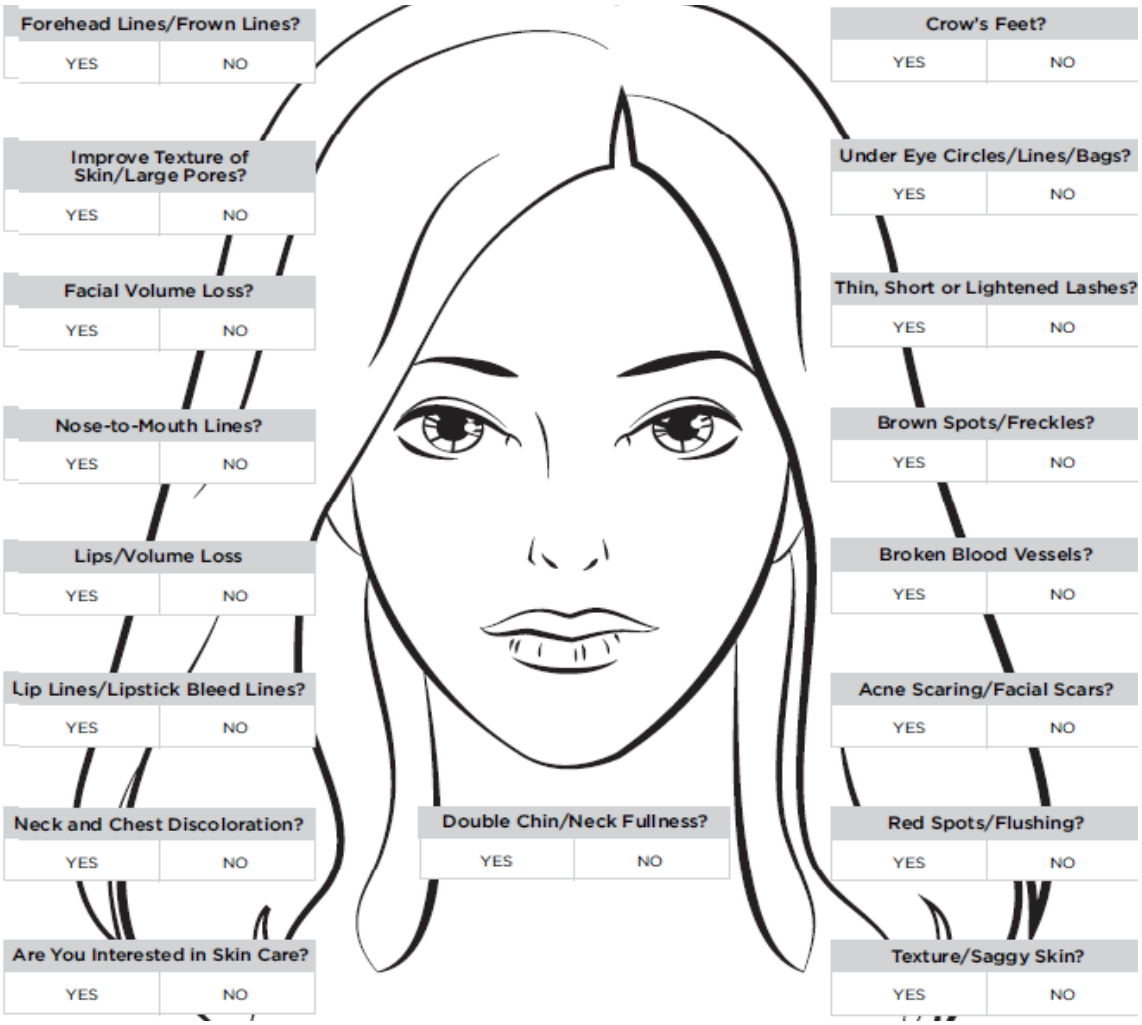
Have you ever been under the care of a dermatologist, plastic surgeon, esthetician, or a medical spa practitioner? _____ What was done? _____

Have you used facial waxes or depilatories in the last 4 weeks? _____

Do you use sun protection daily? _____ Do you use tanning beds? _____

What skin care line/products do you currently use? _____

Please circle the following concerns:



Signature : _____ **DATE:** _____

_____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN