SPA NAMASTE

ESTHETIC PATIENT HISTORY

Name_____D.O.B._____Age_____Sex__ M/F

Address_____City_____PC_____

Home Phone #_____Cell #_____Work #_____

E-mail address_____Referred by_____

What is the reason for your visit today?_____

RELATIVE CONTRAINDICATIONS (please fill out for all treatments including facials)

Have you had a chemical peel within the last 14 days?	Yes____No____
Have you had laser hair removal within the last 14 days?	Yes____No____
Have you had IPL(intense pulsed light) treatments within the last 14 days?	Yes____No___
Have you had RF (Radio Frequency) skin tightening treatments within the last 14 days?	Yes____No___
Have you had microdermabrasion within the last 14 days?	Yes____No____
Have you had waxing, threading or any other form of hair removal in the last 7 days?	Yes____No____
Have you had Botox or dermal fillers in the last 7 days?	Yes____No____
Have you been exposed to the sun in the last 3 weeks?	Yes____No____
Have you used a tanning bed in the last 3 weeks?	Yes____No____
Are you using any topical Retinoid prescriptions?	Yes____No____
Are you using any AHA/BHA skin care products?	Yes____No____
Are you using any prescription topical medications at this time?	Yes____No____
Do you wear contact lenses?	Yes____No____
Do you have permanent make up?	Yes____No____
Do you participate in aerobic physical activity?	Yes____No____
Do you develop cold sores?	Yes____No____
Have you ever used any skin care products that caused a bad reaction?	Yes____No____

What is the ethnic background of your parents?_____

ABSOLUTE CONTRAINDICATIONS (please fill out for chemical peels/microdermabrasion/IPL or laser treatments)

Are you currently using Accutane? Yes____No____
Are you pregnant? Yes____No____
Are you lactating/nursing? Yes____No____
Do you have a cold sore today (herpetic break out)? Yes____No____
Do you have any allergies? If yes, list them_____ Yes____No____

_____

What are the skin concerns that you would like us to help you with_____

_____

TITE FX OR FRACTORA FIRM

Pregnancy or nursing Yes____No____
Under 18 years of age Yes____No____
Pacemaker or internal defibrillator Yes____No____
Permanent implant in the treated area. (Metal plates and screws, silicone implants or an injected chemical substance. Yes____No____

Current or history of cancer, especially skin cancer or pre-malignant moles Yes____No____
Impaired immune system such as HIV and AIDS, or use of immunosuppressive medications Yes____No____

Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension,and liver or kidney diseases. Yes____No____

Diseases stimulated by heat, such as Herpes Simplex in the treated area. Yes____No____
Sores, psoriasis, rash or excessively or freshly tanned skin. Yes____No____
Keloid scarring, abnormal wound healing, very dry and or fragile skin. Yes____No____
Any medical condition that might impair skin healing. Yes____No____
Poorly controlled endocrine disorders. I.e. diabetes or thyroid dysfunction. Yes____No____
Surgical, invasive, ablative procedure in the area in the last 3 months Yes____No____
Superficial injection of fillers in the last 6 months, or Botox in the last 3 months Yes____No____
Use of Accutane in the past 6 months Yes____No____

Patient Signature_____ Date_____

Esthetician Signature_____ Date_____