Health Rhythms Medi Spa & Tan

4250 E. Florida Ave., Hemet, CA 92544

New Patient Information

Laser / MicroDermAbrasion / Esthetician

Name: ______________________ Birthdate: ____________

Address: ______________________ City: ____________ State: ____ Zip: ____________

Phones: Home: ____________ Cell: ____________ E-Mail: ______________________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced # Children ________

Occupation: ○ Full ○ Part-time ○ Self ○ Student Employer: ______________________

Occupation: ______________________ Employer Phone: ____________

General & Medical Information

Have you ever received MicroDermAbrasion before? ○**Yes** ○ **No** How recently? ____________

Have you ever had any laser procedures or chemical peels? ○**Yes** ○ **No** How recently? ____________

Have you ever seen a Doctor regarding this problem? ○**Yes** ○ **No** How recently? ____________

Have you been treated before for this condition? ○**Yes** ○ **No** Did it help? ○**Yes** ○ **No**

What was done? ______________________

Do any of the following apply to you?

○**Yes** ○ **No** Accutane If so, When?

○**Yes** ○ **No** Allergies? Especially skin related?

○**Yes** ○ **No** Taking Aspirin, Ibuprofen?

○**Yes** ○ **No** Autoimmune Disease, HIV, Lupus, Hepatitis?

○**Yes** ○ **No** Birth Control pills, Hormones?

○**Yes** ○ **No** Bruise easily, cuts?

○**Yes** ○ **No** Do you have high blood pressure?

○**Yes** ○ **No** Are you taking high blood pressure medication?

○**Yes** ○ **No** Diabetes (controlled or uncontrolled)?

○**Yes** ○ **No** Eczema?

○**Yes** ○ **No** Herpes, cold sores, fever blisters?

○**Yes** ○ **No** Keloids, pigmented scars?

○**Yes** ○ **No** Irregular, pigmented moles or growths?

○**Yes** ○ **No** Pregnancy, breast feeding?

○**Yes** ○ **No** Stretch marks?

○**Yes** ○ **No** Warts?

○**Yes** ○ **No** Do you drink Alcohol? How often? ________

○**Yes** ○ **No** Do you Smoke?

○**Yes** ○ **No** Are you currently under the care of a physician?

○**Yes** ○ **No** Are you currently taking any other medications?

○**Yes** ○ **No** Do you wear make-up? Brand? ________

○**Yes** ○ **No** Do you take laxatives or diuretics? How often?

○**Yes** ○ **No** Are you under chemotherapy or radiation therapy?

○**Yes** ○ **No** Is your skin sensitive? Oily Dry Combination

○**Yes** ○ **No** Are you currently on a restricted diet?

○**Yes** ○ **No** Glasses of plain water drunk daily? ________

○**Yes** ○ **No** How many caffeinated beverages daily? ______

○**Yes** ○ **No** Are you claustrophobic?

○**Yes** ○ **No** Does your skin ever experience:
Flakiness Tightness Obvious Dryness

○**Yes** ○ **No** Do you use sunscreen? SPF ______

○**Yes** ○ **No** Do you sunburn easily?

○**Yes** ○ **No** Do you blush easily when nervous?

○**Yes** ○ **No** Do you have any other medical condition or are you taking any medications I should know about?

Do you have any drug allergies? ○**Yes** ○ **No** If yes, what? ______________________

Please list creams or products you are using ______________________

Signature: ______________________ Client # ____________ Date: ____________

Print Name of Client: ______________________

Consent to Treatment of Minor:

I HEREBY GIVE MY PERMISSION as Parent [ ] Guardian [ ]

of ______________________ who is ______ years of age, to receive skin care treatments from the professionals at Health Rhythms Medi Spa.

Signature: ______________________ Client # ____________ Date: ____________

Print Name of Parent/Guardian: ______________________

Miscellaneous Information:

Who may we thank for referring you to our office? Advertisement? ○ Yes ○ No Where? ____________

Individual? ○**Yes** ○ **No** Name: ______________________