Personal Profile and Health History

Name: _____ Home Phone:_____

Address: _____ Cell Phone:_____

City/State/Zip: _____

Birth Date: _____Age:_____Gender: M F

Occupation: _____ Email Address: _____

Are you enrolled in Allergan's Brilliant Distinctions?_____ Password:_____

Are you enrolled in Galderma's Aspire Program? _____ Password:_____

What treatments are you interested in?

- ☐ Hair removal
- ☐ Spider vein treatment (laser or injection)
- ☐ Microblading
- ☐ Ultherapy
- ☐ Facial rejuvenation and peels
- ☐ Age spot /freckle treatments
- ☐ Skin tightening
- ☐ Skin care
- ☐ Tattoo Removal
- ☐ Botox / Dysport
- ☐ Fillers
- ☐ Body contouring/ Sculpsure/ Smart Lipo
- ☐ ThermiVa/ Mona Lisa Touch
- ☐ Kybella / Double Chin
- ☐ Skin Resurfacing
- ☐ Lash lift
- ☐ Melasma
- ☐ Other_____

Notes:

_____

_____

Females: Are you pregnant? Yes No Are you breast feeding? Yes No
Are you planning a pregnancy during the course of your treatment? Yes No
Do you have any of the following? Defer questions ☐

- ☐ Urinary frequency or urgency
- ☐ Leakage when you laugh/cough/sneeze
- ☐ Pain with intercourse
- ☐ Vaginal dryness/atrophy
- ☐ Vaginal laxity
- ☐ Lack of sensation with intimacy

Medical History:

_____

Please list ALL medications including prescription and over the counter drugs, vitamins, supplements:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you allergic to latex or any topical or oral medications?

_____

What products do you currently use on your skin? Brand: _____
Retinol?_____ Anti-aging/Growth factor_____
Sunscreen/moisturizer_____

Please check any that apply:

- ☐ Acne
- ☐ Bleeding disorders
- ☐ Burns/ skin grafts
- ☐ Diabetes
- ☐ Endocrine disorders
- ☐ Epidermolysis Bullosa
- ☐ Gold or silver therapy
- ☐ Heart disease
- ☐ Autoimmune Disorders
- ☐ Herpes
- ☐ High blood pressure
- ☐ Hirsutism
- ☐ Hormone replacement therapy
- ☐ Implants
- ☐ Kaposi's sarcoma
- ☐ Keloid scars
- ☐ Lupus
- ☐ Permanent make up
- ☐ Polycystic ovarian disease
- ☐
- ☐ Precocious puberty
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seizures
- ☐ Shingles
- ☐ Skin cancer
- ☐ Tattoos
- ☐ Thyroid disease
- ☐ Vitiligo

Other? _____
Previous Surgeries in the area to be treated? _____

If the answer to any of the following questions is yes, please explain in the space below:

1. Are you currently being treated for any medical conditions? Yes No
2. Have you used Accutane in the past 12 months? Yes No
3. Do you have any skin disease or infections in the area to be treated? Yes No
4. Do you have skin allergies? Yes No
5. Are you currently using Retin-A or Glycolic acid? Yes No
6. Have you had a chemical peel or a facial in the past week? Yes No
7. Do you have any implants or metal anywhere? Yes No
8. Are there any moles with hair in the area to be treated? Yes No
9. Are you using a tanning bed or tanning cream? Yes No
10. Have you had sun exposure in the past 4-6 weeks? Yes No
11. Smoking History: ☐ Never smoked ☐ Quit _____year ☐ Now smoke _____ppd ____years

_____
_____

Who is your family doctor? _____

Please initial the following to statements acknowledging you have read them and understand.
I confirm that the answers to the questionnaire are true and correct. The consultant has clarified any question I did not understand. _____(initial)
I understand that fees for all services at Lewisville Laser and Aesthetics are self-pay and due at time of service.
I decline to file insurance claims for these services _____ (initial)
Deposits are Non-refundable_____(initial)
I understand there is a cancellation fee for failing to give 24 hour notice before appointment _____(initial)

Client Name: _____

Client Signature: _____

Date: _____

How did you hear about us?

- ☐ Forsyth Family / Forsyth Woman Magazine
- ☐ Buena Vista Life
- ☐ Open House
- ☐ Google Search
- ☐ Direct Mail
- ☐ Facebook
- ☐ Instagram
- ☐ Other _____

Who referred you? (so we can thank them!) _____