Conroe Aesthetics & Wellness

Client Information & Medical History

In order to provide you with the most appropriate treatments, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFORMATION:

Patient Name: _____ **Today's Date:** _____

Date of Birth: ____/____/____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

May we send you text confirmations for future appointments etc.? Yes or No

If yes please list cell phone provider (AT&T/Verizon, etc): _____

Email: _____

May we send you e-mail confirmations for future appointments etc.? Yes or No

May we place you on our monthly e-mail news letter for specials, events, etc.? **Yes** or **No**

Emergency Contact Name & Phone Number: _____ Relationship? _____

How did you hear about Conroe Aesthetics & Wellness: _____

MEDICAL INFORMATION:

Are you currently under the care of a Physician? **Yes** **No** If yes, for what: _____

Are you currently under the care of a Dermatologist? **Yes** **No** If yes, for what? _____

Please circle any of the medical conditions below that apply to you:

- Cancer
- Chemotherapy/Radiation
- Heart Disease/ Heart Murmur
- Chest Pain
- High Blood Pressure
- Anemia
- Diabetes
- HIV /AIDS
- Hepatitis
- Seizure Disorder
- Thyroid Imbalance
- Hormone Imbalance

- Eye Disease
- Sinus Problems
- Active Infections (ex. Staph, etc)
- Keloid Scarring
- Frequent Cold Sores
- Skin Disease/Skin Cancer
- Acne
- Arthritis
- Blood Clotting Abnormalities
- Mental Disorder
- Sensitivity to adhesives
- PCOS (Polycystic ovary syndrome)

Please explain any of the above circled conditions: _____

Please list any drug allergies: _____

Please list all current medications and vitamin/ natural supplements that you are taking: _____

_____

_____

Are you pregnant or trying to get pregnant? **Yes** **No** Breast feeding? **Yes** **No**

Have you ever used Accutane? **Yes** **No** If yes, when was the last time you used it? _____

Are you currently taking:

Birth Control Pills **Hormones** **Mood Altering or Anti-Depressants** **Topical Medications or Creams**

AESTHETIC HISTORY:

Do you smoke? **Yes** **No** (How often) _____ Do you live with a smoker? **Yes** **No**

Do you drink alcohol? **Yes** **No** (How often) _____ How much water do you drink daily? _____

Do you exercise? **Yes** **No** If so, how often: _____ Do you use tanning beds? **Yes** **No**

Date of last sun exposure? _____

Please circle your skin concerns:

Sun Spots	Rosacea/ Flushed Cheeks	Hyper pigmentation (brown spots)	Hypo pigmentation (white spots)
Skin Laxity	Thin Eyelashes	Oiliness	Broken Capillaries
Skin Texture/Tone	Thin/Fragile Skin	Unwanted Hair	Fine lines/ Wrinkles
Lines around nose and mouth		Acne	Spider Veins	Dehydrated Skin

Please circle the treatments that you have had in the past:

Botox Injections	Laser Skin Rejuvenation (Photo Facials/skin Tightening)	Dermal Fillers (ex. Juvederm)	HydraFacials
Laser Hair Removal	Sclerotherapy (for spider veins)	Chemical Peels	Waxing
Dermal Planing	Microdermabrasions	Facial Treatments	

Please asterisk any of the above treatments that you may be interested in.

I acknowledge that all above information is true and correct. I am aware that it is my responsibility to inform the physician, aesthetician, technician, etc. of any new medical or health conditions.

Patient Signature _____ **Date** _____