Muse MedSpa

Client Information & Medical History

PERSONAL HISTORY

Client Name____ Today's Date_____________________

Date of Birth_____________________________________Age___________Occupation__________________

Home Address____

City____________________________________ State___________________________ Zipcode_____________

Contact Phone____ Cell Phone provider___________________

E-Mail____ email updates okay? Yes No

How were you referred to us? ____

SKIN

Which of the following best describes your skin type? (Please circle one)

I Fair skin, always burns, never tans
II Light skin, always burns, sometimes tans
III Medium tone, sometimes burns, always tans
IV Olive tone, rarely burns, always tans
V Darker brown/black, never burns
VI Darkest skin tone

Please circle any concerns regarding your skin:

Uneven Skin Tone
Brown Spots (Hyperpigmentation)
Acne
Clogged Pores Blackheads
Whiteheads / Milia
Excessive Oiliness
Bumps Under Skin
Scarring
Fine Lines/Wrinkles
Dryness
Sensitivity/Redness
Skin Laxity
Unwanted Hair
Visible Capillaries

Please List Other Concerns:____

Please check the prescription medications you are currently using:

Accutane Differin Retin-A, Renova, Kinerase Tazorac Antibiotics

Other please list:____

MEDICAL HISTORY

Do you have any of the following medical conditions? (Please check all that apply)

Frequent Cold Sores
Seizure disorder
Skin disease/Skin lesions
High Blood Pressure
Keloid scarring
Blood clotting abnormalities
Hormone imbalance
Thyroid imbalance
HIV/AIDS
Arthritis
Diabetes
Hepatitis
Herpes
Any active infection
Cancer

Do you have any other health problems or medical conditions? Please list:

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Have you visited or plan to visit the dentist within two weeks?_____________________________________

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced)

Food ________________________________Latex____
Aspirin______________________________Lidocaine_____________________________________
Hydrocortisone______________________Other____

MEDICATIONS

What oral medications are you presently taking? Birth Control Pills Hormones
Other (Please list)____
Are you on any mood altering or anti-depression medication? Yes No
Have you ever used Accutane? Yes No If yes, when did you last use it? ______________________
Are you using any topical medications or creams? Retin–A Hydroquinone
Other (Please list)____

Have you recently used any tanning lotions, treatments or recent sun exposure? Yes No
Do you form thick or a raised scar from cuts or burns? Yes No

For our female clients:

Are you pregnant or trying to become pregnant? Yes No
Are you breastfeeding? Yes No
Are you using contraception? Yes No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

I agree and have been informed that treatments for acne scarring and melasma require ongoing treatment plans.

I agree to a $50 fee if I do not show up or cancel the day of any appointment that I have booked.

Client Signature ____ Date__________________

Witness Signature____ Date__________________

For Office Use Only

Approved for the following services:

IPL PhotoFacial	Microneedling	Injectable Treatments
Vascular Treatment	Fractional Laser	Body Contouring

MD/PA-C Signature____Date_____________________________