Vibrance medical spa — Patient Information

General Information

Name: _____ Today's Date: _____

Address: _____

City, State, Zipcode: _____

Home Phone: _____ Cell Phone: _____

Email: _____ May we send text appt. reminders? ☐ Yes ☐ No

May we send you emails relating to our specials and events? ☐ Yes ☐ No

Date of Birth: _____

Occupation: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____

Skin History

☐ Acne/Acne scarring	☐ Unwanted Hair	☐ Skin Laxity
☐ Brown Spots/Sun Damage	☐ Pigmented Lesions	☐ Skin Texture/scars
☐ Spider Veins	☐ Rosacea	☐ Flushing of the skin
☐ Fine Lines & Wrinkles	☐ Melasma	☐ Crow's Feet
☐ Dry Skin	☐ Large pores	☐ Deep Lines/Shadows

How long have you had these concerns? _____

Do you feel that your condition is worsening? ☐ Yes ☐ No

Have you ever been treated for this?

If yes, please explain: _____

_____

Are you currently taking medication for a skin condition? ☐ Accutane

☐ Retin-A ☐ Hydroquione or bleaching agent ☐ Antibiotic: _____

Do you get cold sores or fever blisters? ☐ Yes ☐ No

Do you form thick or raised scars (keloid)? ☐ Yes ☐ No

Do you develop hyperpigmentation? ☐ Yes ☐ No ☐ I don't know

When were you last exposed to direct sun or a tanning booth? _____

Do you use self-tanning products? ☐ Yes ☐ No

Are you planning a vacation in the sun in the next 3 months? ☐ Yes ☐ No

Have you ever used any of the following:

☐ Depilatories ☐ Shaving ☐ Waxing ☐ Stringing ☐ Tweezing

Do you get facials? ☐ Yes ☐ No

Have you ever had skin acid peels? ☐ Yes ☐ No

Have you ever had Microdermabrasion? ☐ Yes ☐ No

What type of skincare products do you currently use?

Have you ever had treatment for brown lesions or sunspots? ☐ Yes ☐ No

Have you ever had Botox or Filler treatments? ☐ Yes ☐ No

Personal History

Do you smoke? ☐ Yes ☐ No If yes, how many per day: _____

Do you consume alcohol? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Cosmetic History

List all (or last) laser and/or injectables such as Botox, Restylane, Radiesse, collagen, fat or other:

Date	Area	Any Adverse Reactions

Medical History

Are you currently under the care of a physician? ☐ No ☐ Yes _____

Do you have any of the following conditions?

☐ Arthritis	☐ Chest Pain	☐ HIV/AIDS
☐ Any active infection	☐ Epilepsy or seizures	☐ Neurologic disorder
☐ Bleeding disorders	☐ Heart Disease	☐ Sensitive teeth
☐ Bruising	☐ Hepatitis	☐ Skin cancer or moles
☐ Dark spots from pregnancy	☐ Herpes simplex	☐ Skin injury
☐ Diabetes	☐ High blood pressure	☐ Vision deficits
☐ Cancer	☐ Hormone imbalance	☐ Thyroid disease

☐ Other: _____

Do you have allergies to any of the following:

☐ Topical skin care products ☐ Anesthesia ☐ Latex ☐ Food ☐ Plants

☐ Medications:

Do you take any of the following:

☐ Accutane ☐ Appetite suppressants ☐ Insulin

☐ Antibiotics ☐ Aspirin or Ibuprofen ☐ Sedatives

☐ Blood thinners ☐ Cortisone or steroids ☐ Thyroid medication

☐ Anti-Depressants ☐ Hormone/contraceptives

☐ Other:

Are you taking supplements or vitamins? (St John's Wort, Vitamin E, Fish Oil) ☐ Yes ☐ No

List all surgeries:

Date	Procedure	Surgeon

Do you have any issues with bruising or bleeding? ☐ Yes ☐ No

Have you ever had an issue with your nerves or muscles? (Strokes, Bell's palsy, nerve injury, etc.)

Do you need to take antibiotics before procedures such as dental? ☐ Yes ☐ No

Do you suffer from any neurological disorders? (Myasthenia Graves, MS, Lambert-Eaton Syndrome, ALS)

Do you have a pacemaker or other implantable device? ☐ Yes ☐ No

For female patients

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Do you have regular periods? ☐ Yes ☐ No

I have answered the questions contained in this questionnaire to the best of my knowledge.

I understand it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are

changes to my health in between treatments.

Signature: _____ Date: _____