ALABAMA VEIN & RESTORATION MEDSPA

MedSpa New Patient Information and Medical History

Name_____ Sex: M F Date of Birth_____

Address_____ City_____ Zip_____ State _____

Phone_____Emergency Contact Name & Phone_____

Email_____ How did you hear about us?_____

Would you like to receive our specials by email? Yes ☐ No ☐

What Services and Treatments are you interested in? Please (X) all that apply.

	(X)
Botox	
Filler	
Lash Lift	
SkinPen	
Laser Hair Removal	
Spider Vein Treatment	
Laser Facial	
Hyperpigmentation (brown spot removal)	
Chemical Peels	
Dermaplane	
Microdermabrasion	
Waxing	
Hormone Replacement Therapy	

Alabama Vein & Restoration Medspa
4721 Chace Circle
Hoover AL 35244
205-823-0151
www.alabamaveincenter.com

Medical Conditions:	**Current Medications: (Topical & Oral)**	**Past Surgeries and the year:**	**Allergies:**
Skincare Products currently using:			

Client Signature _____ Date_____

Office Use:

Skin Type (circle one)		**Hair Color**
I-II: Very Fair – Fair	***(burns easily)***	**Grey**
III: Medium	***(tans gradually)***	**Blonde**
IV: Moderate Brown	***(Asian/Hispanic)***	**Brown**
V: Very Dark	***(Dark Hispanic)***	**Black Red**
VI: Very Dark Brown	***(African-American)***	

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Client History Form

YES	NO	Are you pregnant or nursing?		YES	NO	Do you consume aspirin daily?
YES	NO	Have you had any alcohol in the last 24 hours?		YES	NO	Do you have any type of hepatitis or HIV?
YES	NO	Have you ever had cold sores or fever blisters?		YES	NO	Are you sensitive to petroleum-based products?
YES	NO	Do you have any allergies to latex?		YES	NO	Do you have Botox injections?
YES	NO	Have you had a laser or chemical peel within 6 months?		YES	NO	Are you undergoing radiation or chemotherapy treatment?
YES	NO	Do you bruise easily?		YES	NO	Are you now, or have you ever been on the acne treatment Accutane?
YES	NO	Do you routinely use Retin-A, glycolic, or other exfoliating products?		YES	NO	Are you wearing a pacemaker?
YES	NO	Do you wear contact lenses?		YES	NO	Are you taking Hormone Replacement therapy?
YES	NO	Are you allergic or sensitive to any metals, for instance, metals used for jewelry?		YES	NO	Are you anemic?
YES	NO	Do you have any problems healing from small wounds?		YES	NO	Do you have a history of skin sensitivities?
YES	NO	Do you use Latisse or any other eyelash growth product?		YES	NO	Do you have any medical condition that has resulted in a medical professional requiring you to premedicate with an antibiotic prior to a dental or other invasive procedure?
YES	NO	Do you use tobacco?		YES	NO	Do you have allergies to topical makeup?
YES	NO	Do you have any heart conditions?		YES	NO	Do you have dry eyes?
YES	NO	Are you diabetic? If so, Type 1 or Type 2?		YES	NO	Do you intentionally tan—direct sun or tanning bed?
YES	NO	Do you have any autoimmune disorders?		YES	NO	Do you personally have any history of cancer?
YES	NO	Are you sensitive or allergic to hand creams or body lotions?		YES	NO	Do you have a history of stroke or heart attack?
YES	NO	Do you have your lips injected with filler materials?		YES	NO	Do you have problems being anesthetized for a dental procedure?
YES	NO	Do you hyperpigment?		YES	NO	Do you hypopigment?
YES	NO	Do you tend to develop keloid or hypertrophy scars?		YES	NO	Are you allergic to hair dyes?
YES	NO	Do you scar easily from minor skin injuries?		YES	NO	Do you have glaucoma or any other eye diseases?
YES	NO	Do you have any seizure related conditions?		YES	NO	Do you have arthritis?
YES	NO	Do you have a tendency to faint or become dizzy?		YES	NO	Do you have high or low blood pressure?
YES	NO	Do you bleed excessively from minor cuts?		YES	NO	Do you have sinus problems?

If you answered “yes” to any questions above, use the space below and the reverse side of this form to provide an explanation. Correlate your explanations to a specific question number. A “yes” answer does not indicate you are not an acceptable candidate for permanent cosmetics. It may simply be information that is valuable to me as your technician as each person’s body is unique, or it may indicate that based on any health conditions that affect healing, it would be advisable or required for you to consult with your physician before proceeding. If this form has not addressed a medical condition you have, please list it below.

_____

_____

_____

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