Name:_______________________________ Date of Birth:________________ Age:___________
Address:_____________________________ City:______________ State:_________ Zip: _______
Phone Number:________________________ Email Address:_______________________________
Sex: M or F Can we include you on our email list: Y or N

Can we leave a message at this number? □Yes □ No Text Confirmation: □ Yes □ No
How did you hear about us? ____

Please check if you have any of the following:

□ Asthma	□ Cold Sore/fever blister	□ Hysterectomy	□ Pacemaker
□ Cardiac disorders	□ Headaches-chronic	□ Immune Disorders	□ Sinus Problems
□ Depression/Anxiety	□ Hepatitis	□ Lupus	□ Skin Diseases
□ Eczema	□ Herpes	□ Implants	□ Kidney Problems
□ Urinary Problems	□ High Blood Pressure	□Pins or Plates	□ Bleeding disorder
□ Diabetes	□ Rheumatoid Arthritis	□ Accutain	□ Allergies

Other please list____

Do You or a Family member have:
ALS, Motor Neuropathy, Myathenia Gravis, Lambert Eaton Syndrome, Facial Nerve Palsy/Bells Palsy, Autoimmune Disease; Please explain if yes: ____________________________________

Are You……. □ Pregnant □ Trying to get Pregnant □ Breastfeeding □ Lactating

What is your genetic background: □ African American □Asian □Caucasian □Hispanic
□ Mediterranean □Middle Eastern □Native American □ Other _________________________
Natural Eye Color?_______________ Natural Hair Color?_________________ Skin Tone________

Does your skin have any of the following, check all that apply:

□Normal	□ Milia	□Eczema	□Breakouts	□Dry
□Dark Circles	□Cystic	□Freckled	□Oily	□Large Pores
□Hyperpiqmentation	□Dehydrated	□Acne	□Rocacea	□ Small Pores
□Hypopigmentation	□Telanglectasia/Veines		□Broken Capillaries	

Do You Consider your skin: □Sensitive □Resilient □Unsure

What bothers you about you skin what do you want to improve on____

____

Allergies to Medications: ____
Allergies to Food: ____
Medications you take: ____

____

Do you take or recently been on any of the following medications:
Please Circle all those that apply.
Warfarin, Plavix/Anti Platelets/Blood thinners , fish oil, Vitamin, Aspirin, Ibuprofen, Advil, Motrin, Aleve, Multivitamins, Herbs. Garlic, Ginko, Ginseng, other_________________
When did you last take:____

Have you had any surgeries?____
Do you have any injectables or dermal fillers? If so what area______________________

Have you been exposed to the sun within the last four to six weeks OR self tanners? If yes please explain:

Check those that apply:

□ Tobacco products □ Experience Stress □ Do you participate in Vigorous exercise or sports
□ Wear contacts □ Use tanning beds or products □ Have permanent makeup
□ Tattoos

Have you had professional skin care in the past? □ yes □ No
Do you use sunscreen daily? □ yes □ No

Current Skin regimen and products you use:
AM:____
PM:____

How many glasses of water do you drink daily? __________________________

Signature_______________________________, Nurse Signature__________________________

Refresh Your Spirit Aesthetics LLC