PARADISE ON COLUMBIA
MED SPA

Medical History Form

Date: _____

Last Name: _____ First: _____ Middle: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Can we contact you by email? _____

Date of Birth: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us? _____

Specify your genetic origin: □African American □Asian □Caucasian
□Hispanic □Mediterranean □Middle Eastern
□Native American □Other

Females: Are you Pregnant? □Yes □No
Are you Breastfeeding? □Yes □No
Are you planning pregnancy during the course of your treatment? □Yes □No
During pregnancy, did you develop hyperpigmentation or masking? □Yes □No
Do you have regular periods? □Yes □No
Are you presently going through menopause? □Yes □No

Complete the Following items of your medical history. Always inform us of any change in your medical history and/or medications.

List all medications you are currently taking, including prescriptions, over-the-counter drugs, vitamins, herbs, and supplements. _____
_____

Are you using any medications purchased outside the USA? □Yes □No
Are you allergic to any medications? □Yes □No
List any medication reactions: _____
Are any of your medications photo sensitive? □Yes □No

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Medical History: Please check all that Apply.

□Acne
□Bleeding Disorders
□BOTOX Cosmetic treatments
□Burns/Skin grafts
□Diabetes
□Endocrine Disorders
□Epidermolysis Bullosa
□Filler Injections
□Gold Therapy
□Heart Disease
□Hemorrhoids
□Herpes/Cold Sores
□High Blood Pressure
□Hirsutism
□Hormone Replacement RX
□Implants
□Kaposis Sarcoma
□Keloid Scars
□Lupus erythematosus
□Permanent Makeup
□Polycystic Ovary Disease
□Port-Wine Stain
□Precocious Puberty
□Psoriasis
□Rosacea
□Seizures
□Shingles
□Skin Cancer
□Tattoos
□Thyroid Disease
□Vitiligo
□Pacemaker
□Other: _____
_____

Please Answer the following questions:

1.Are you currently being treated for any medical condition? □Yes □No
Explain: _____
2.Have you ever seen a physician regarding your skin? □Yes □No
3.Do you have any active skin diseases or infection in the area to be treated? □Yes □No
4.Do you have any skin allergies? □Yes □No
5.Have you had skin cancer or pre-cancerous lesions? □Yes □No
6.Do you have psoriasis/eczema in the area to be treated? □Yes □No
7.Are there any moles with hair in the area to be treated? □Yes □No
8.Are you allergic to latex, lidocaine, or any lotions? □Yes □No
9.Have you ever had surgery in the area to be treated? □Yes □No
10.Have you had any previous skin treatments in the area to be treated? □Yes □No
Explain/Give Dates: _____
11.Have you/are you using medications such as Accutane? □Yes □No
Date of last use: _____
12.Are you using Retin-A, Renova, Differin, or Tazorac? □Yes □No
Concentration: _____%_____
13.Are you using glycolic/AHA home care products? □Yes □No
14. What skin care products are you currently using? _____
_____
15.Do you Smoke? □Yes □No
16.Do you sunbathe? □Yes □No
Approximately date of last sun exposure: _____
17.Are you currently using, or have you used a tanning bed or self-tanner? □Yes □No
Date of last use: _____
18.Do you use sunscreen? □Yes □No
Summer SPF_____ Winter SPF_____
19.Do you use facial depilatories? □Yes □No
20.Do you use hot wax? □Yes □No
21.Does your skin remain discolored after healing from a cut? □Yes □No
22. Have you ever had Botox/Fillers? □Yes □No
23. Do you keloid from a cut? □Yes □No

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Please indicate which of the following concerns you have about your skin:

□Aged Skin	□Sun Damage	□Rosacea	□Age Spots
□Acne	□Enlarged Pores	□Blackheads	□Texture
□Redness	□Wrinkles	□Whiteheads	□Other: _____
□Leg Veins	□Hair Removal	□Oily Skin	_____
□Spider Veins	□Uneven Tone	□Dry Skin	
□Scarring	□Hyperpigmentation	□Sensitive Skin	

What area would you like to treat?

□Face & Neck □Chest □Arms □Hands □Back □Legs □Other

Please Indicate the service(s) you are interested in or would like more information about:

□Hair Removal	□Acne Treatment	□Rosacea Treatment	□Peels
□Vein Treatment	□Pigment Treatment	□Sun Damage Treatment	□Dermaplaning
□Age/Liver Spot Treatment	□Wrinkle Treatment	□Redness/Vessels	□Microneedling

I confirm that answers to this questionnaire are true and correct.

Signature of Client: _____ Date: _____

Reviewed by Laser Technician/Aesthetician: _____ Date: _____

Reviewed by Medical Doctor: _____ Date: _____