

The Medical Spa

@ GMG

660 Summit Crossing Place Suite 301

Gastonia, NC 28054

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Email Address _____

Date of Birth _____ Age _____ Sex _____

HISTORY

Please check if you have or have had:

_____ Diabetes	_____ Irregular menses
_____ Hepatitis	_____ Heart problems
_____ Herpes	_____ Hysterectomy
_____ Menopause	_____ Hypertension
_____ Sensitive to anesthetic	_____ Photosensitive disorder
_____ Lupus	_____ Autoimmune illness

Are you under the care of a physician? _____

Current/Recent medications _____

			<u>If yes please explain</u>
Keloid scars	Yes	No	_____
Hives	Yes	No	_____
Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Cold Sores	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin infections	Yes	No	_____
Tanning within the last 6 wks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Medical Illness _____

Are you pregnant? _____

Allergies of any kind including drugs _____

Areas of interest for aesthetic treatment _____

Type of treatment requested _____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature _____ Date _____