ESSEX
MEDSPA

Name_____Today's date _____
LAST FIRST
Address_____ Birthdate _____ /_____/_____
City_____ State_____ Zip_____ Home Phone _____

What number do you prefer to be reached at? Work__ Home __ Cell__ Cell Phone_____
Can we leave a message at this preferred number? Yes__ No__ Work Phone_____
Age_____ Occupation_____ Gender M__ F__
Email address_____
Emergency Contact Name and Phone Number_____
How did you hear about us?_____

Which of the following best describes your skin type? (Please circle one type number)

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tan
V	Brown, moderately pigmented skin
VI	Black skin

Your genetic background affects your skin and its response to certain types of skin treatment.
Please specify your ethnic origin:
African American____ Asian____ Caucasion____ Hispanic____ Mediterranean____
Middle Eastern____ Native American____ Other____

Female Clients: Are you pregnant or trying to become pregnant? Y / N
Are you using contraception? Y / N Are you breastfeeding? Y / N

What skin problems concern you the most? (Check all that apply):

❑ Sun Damage	❑ Brown spots (hyperpigmentation)	❑ White spots (hypopigmentation)
❑ Uneven skin tone	❑ Visible exposed blood vessels	❑ Hard bumps under skin
❑ Enlarges pores	❑ Clogged pores	❑ Blackhead/Whiteheads
❑ Acne	❑ Excessive oiliness	❑ Pimples
❑ Upper lip lines	❑ Wrinkles	❑ Scarring
❑ Sun Spots	❑ Dry patches	❑ Unwanted Hair

Other_____

Please check all home care products that you currently use and list the Brand Name:

- ❑ Cleanser_____
- ❑ Moisturizer_____
- ❑ Night Cream_____
- ❑ Eye Cream_____
- ❑ Toner/Astringent_____
- ❑ Salicylic_____
- ❑ Glycolic_____
- ❑ Mask _____
- ❑ Retin-A Cream_____
- ❑ Sunscreen _____
- ❑ Hydroquinone_____
- ❑ Vitamin C_____
- ❑ Other _____
  _____

Have you undergone any of the following treatments? (check all that apply)

	Last treatment date
❑ Dermal fillers (Juvederm, Restylane, Radiesse, Collagen, Other)	_____
❑ Botox	_____
❑ Sculptra	_____
❑ Laser hair removal	_____
❑ IPL (photofacial)	_____
❑ Sclerotherapy (injection of leg veins)	_____
❑ Microdermabrasion	_____
❑ Chemical Peel	_____
❑ Accutane	_____
❑ Thermage	_____
❑ Fraxel/Pixel	_____
❑ Titan	_____
❑ Cosmetic Surgery	_____

List all medications that you are currently taking or have taken in the last week: (prescription, herbal, and over the counter meds)

_____ _____
_____ _____
_____ _____

Have you taken antibiotics in the last week? Y / N
Specify:_____

Are you allergic to medications? (include prescription and over the counter meds, and the type of reaction)

_____ _____
_____ _____

Are you allergic to latex, lidocaine or any lotions? Y / N
Specify:_____

Are there any open wounds or infections in the area being treated? Y / N
Specify:_____

If you are getting laser hair removal:

Are there any moles in the area being treated?	Y / N
Have you used a tanning bed or tanning cream in the last 6 weeks?	Y / N
Have you been exposed to the sun in the last 6 weeks?	Y / N
Do you form thick or raised scars from cuts or burns?	Y / N

Medical History: (check all that apply)

__Acne	__High Blood Pressure	__Precocious Puberty
__Bleeding Disorders	__Hirsutism	__Psoriasis
__Burns/Skin Grafts	__Hormone Replacement Tx	__Seizures
__Diabetes	__Implants	__Shingles
__Endocrine Disorders	__Kaposi's Sarcoma	__Skin Cancer
__Epidermolysis Bullosa	__Keloid Scars	__Tattoos
__Gold Therapy	__Lupus	__Thyroid Disease
__Heart Disease	__Permanent Makeup	__Vitiligo
__Hemorrhoids	__Polycystic Ovarian Disease	__Port Wine Stain
__Herpes	__Other_____	

Name of your family doctor _____ Phone Number _____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, nurse, or doctor of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____