FOREVER YOUNG MEDICAL SPA
Laser & Skin Rejuvenation

PATIENT HISTORY QUESTIONNAIRE

Name		Date	
Address		City/ZIP	
		Telephone	
Telephone		Mobile	
Date of Birth		E-mail	
Emergency Notification Name		Emergency Phone	

How did you hear about us? _____**If referred, who?** _____

Reason for consultation (please check off all that apply)

Skin rejuventation		Acne	
Hair removal		Scar removal	
Vein removal		Skin Tightening	
Botox/Filler		Mesotherapy/Lipo	
Other			

Have you ever had any of the following conditions (please check off all that apply)

Aids		Hay Fever		Pregnant (LMP)	
Anemia		Heart Disease		Skin Conditions	
Arthritis		Hepatitis		Sinus Problems	
Auto Immune Deficiency		Herpes		Smoker (Pack/Day)	
Asthma		High Blood Pressure		Stomach Problems	
Blood Disease		Kidney Disease		Tan Booth/ Outside Tanning	
Circulatory Problems		Liver Disease		Thyroid Disease	
Chemotherapy/Radiation		Lupus		Cold Sore (frequency)	
Diabetes		Melanoma		Fever Blister (frequency)	
Fainting/Dizzy Spells		Mental Disorder		Other	

Allergies (medications, cosmetics, latex, etc.) _____

Have you ever/are you currently using:

Retin-A, Renova, retinoic acid products	Yes	No	Accutane	Yes	No
Prescription Acne medication	Yes	No	Birth Control Pills/Patch	Yes	No
Steroids	Yes	No	Other:		

Previous Cosmetic Facial Treatments	Yes/ No	Date			
Acid Peel			Waxing		
Botox			Facial Surgery		
Collagen			Laser Surgery		
Tattoo/Permanent Make-up			Microdermabrasion		