VIDA
aesthetic medicine

Client Registration and Medical History

Name: _____ **Date of Birth:** _____

Address: _____ **OK to send mail?** ☐ Yes ☐ No

_____ **Occupation:** _____

Cell Phone: _____ **OK to leave detailed phone message? ☐ Yes ☐ No**

E-mail: _____(We *never* share our mailing list)

Notify me of monthly specials and events? ☐ Yes ☐ No

Appointment Confirmation Preference: ☐ Text ☐ Email ☐ Call

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

How did you hear about us? (Check all that apply) ☐ Google ☐ Facebook ☐ Billboard ☐ Online Search
☐ Driving by ☐ Online Ad ☐ Instagram ☐ I'm a current patient
☐ Friend: (Name) _____ ☐ Other_____

Medical History

Please list any **past** or **current medical conditions**:

_____

_____

☐ Rosacea ☐ Low Thyroid ☐ Cancer ☐ Anxiety

Please list **all prescription medications** you use and why: _____

_____

☐ Aspirin ☐ Cortisone (Steroids) oral or topical
☐ Blood Thinners ☐ Contraceptives/IUD
☐ Antibiotics ☐ Hormones ☐ Insulin ☐ Thyroid

List any **over the counter medications** and/or **herbals/supplements**:

_____

☐ St John's Wort ☐ Fish Oils ☐ Multivitamins
☐ Ibuprofen ☐ Vitamin E ☐ Diet Pills ☐ Aspirin

List any **hospitalizations or surgeries**:(i.e. facial surgery)

_____

_____

Have you ever seen a dermatologist / physician for your skin? ☐ Yes ☐ No
Physician Name: _____
Do you have **medication allergies**? ☐ Yes ☐ No
Details: _____

_____

Date of Last Menstrual Cycle: _____
Are your cycles **irregular**? ☐ Yes ☐ No

Have you ever had any of the following?

☐ Yes ☐ No EVER had cold sores or herpes?
☐ Yes ☐ No Lidocaine or Latex Allergy?
☐ Yes ☐ No Problems with Dermal Fillers/Botox?
☐ Yes ☐ No Autoimmune Disorder?
☐ Yes ☐ No HIV / AIDS?
☐ Yes ☐ No Hepatitis B or C?
☐ Yes ☐ No History of Skin Cancer?
☐ Yes ☐ No Are you Pregnant?
☐ Yes ☐ No Are you trying to get pregnant?
☐ Yes ☐ No Are you breast-feeding?
☐ Yes ☐ No Polycystic Ovarian Syndrome?
☐ Yes ☐ No Blood clots?
☐ Yes ☐ No Bleeding Disorder?
☐ Yes ☐ No Hernias?
☐ Yes ☐ No Poor Healing? / Keloid Scarring?
☐ Yes ☐ No Collagen Vascular Disorder?
☐ Yes ☐ No Heart valve surgery?
☐ Yes ☐ No Irregular Heart Beats?
☐ Yes ☐ No Problems with surgical stiches?
☐ Yes ☐ No History of seizures?
☐ Yes ☐ No Light Stimulated Disease?

Have you ever had any of the following? (continued)

☐ Yes ☐ No Diabetes?
☐ Yes ☐ No Dark spots after pregnancy / melasma?
☐ Yes ☐ No Cancer? Type: _____
☐ Yes ☐ No Immunodeficiency?
☐ Yes ☐ No Smoker? ☐ Past ☐ Current

Has anyone in your family had any of the following?

☐ Yes ☐ No **Skin Cancer**?
Relationship: _____ Type:_____
☐ Yes ☐ No Dark Spots after Pregnancy?

SKINCARE PRODUCTS

☐ At home chemical peels, microdermabrasion, or microneedling: Last used: _____
☐ Retinol Last used: _____
☐ Retin A(Tretinoin) / Differin Last used: _____
☐ Alpha or Beta Hydroxyacids Last used: _____
☐ Accutane (if yes, When?) Last used: _____
☐ Bleaching Cream Last used: _____
☐ Acne Products Last used: _____
Details: _____

Have you had any of the following?

☐ Facial Surgery Month/Year: _____
☐ Facial Implants Month/Year: _____
☐ Dermal Fillers Month/Year: _____
☐ Liposuction Month/Year: _____
☐ Deep chemical peels Month/Year: _____
☐ Co2 Laser Resurfacing Month/Year: _____
☐ Permanent Cosmetics Month/Year: _____

In order for us treat your skin appropriately, we need to know more about the pigment in your skin. **Please tell us about your ethnic background:** (Check **all** that apply)

☐ Olive/ Mediterranean (Spain, Portugal, Greece, Haitian, Italian)
☐ Native American/ Aztec?
☐ Hispanic-country?
☐ African American
☐ Asian – country?
☐ Not sure, but I tan easily

What skin care products are you currently using?
_____

1. Have you had recent tanning or sun exposure? *If yes, please specify:* _____ ☐ Yes ☐ No
2. Are you planning a holiday in the sun? *If yes, When?*_____ ☐ Yes ☐ No
3. Do you use prescription skincare products? (steroids, skin lighteners, antibiotics) ☐ Yes ☐ No
   If yes, please specify: _____
4. Have you recently used any self-tanning lotions / treatments? ☐ Yes ☐ No
5. Have you recently used Accutane, Retin-A(Tretinoin) or sun sensitive medications? ☐ Yes ☐ No
   If yes, please specify: _____
6. Do you get lightening or darkening of the skin after physical trauma? ☐ Yes ☐ No
7. Do you have skin related allergies? *If yes, please specify:* _____ ☐ Yes ☐ No

LASER HAIR REMOVAL CLIENTS ONLY

1. Have you ever had hair removal? ☐ Yes ☐ No
2. In the past six weeks, have you done:
   ☐ Waxing ☐ Tweezing ☐ Threading ☐ Electrolysis
3. Does excessive hair growth run in your family? ☐ Yes ☐ No
4. Have you had a recent growth in excess hair? ☐ Yes ☐ No
5. Have you ever been diagnosed with Polycystic Ovarian Syndrome? ☐ Yes ☐ No
6. Are your menstrual cycles regular? ☐ Yes ☐ No
7. Has a doctor ever obtained hormone levels from you? ☐ Yes ☐ No

I certify that the preceding medical, personal, and skin history statements are true and accurate to the best of my knowledge. I am aware that it is my responsibility to inform the doctor, nurse, or esthetician of my current medical or health conditions and to update any changes to this history. A current medical history is essential for the provider to execute appropriate treatment procedures. This form must be updated yearly, signed and dated.

Client Name: _____ Signature: _____ Date: _____
(Parent/Guardian, if under 18)

Provider: _____ Signature: _____ Date: _____

Witness: _____ Signature: _____ Date: _____

PRINT SUBMIT