Facial Consultation

First Name _____ MI _____ Last Name _____ DOB _____ Age _____

Street Address _____ City _____ State _____ Zip Code _____

(_______)_____
Best contact number _____ Email Address _____

Emergency Contact Information
In case of an emergency please contact: _____
Relationship to you:_____ Contact Number:_____

Which conditions do you want to improve (please check all that apply):
__ Hyperpigmentation (Brown Spots) __ Acne/Acne Scarring __ Sun Damage __ Enlarged Pores
__ Fine Lines & Wrinkles __ Age Spots __ Surgical Facial Scars
Other:_____

Have you ever had or are you currently experiencing any of the following?

Condition			Condition		
Acne	Y	N	Lupus/SLE	Y	N
Anorexia	Y	N	Lymph Disorder	Y	N
Anemia	Y	N	Migraines	Y	N
Asthma	Y	N	Multiple Sclerosis	Y	N
Bleeding Tendency	Y	N	Pacemaker/Electrical Implant	Y	N
Blood Disorder	Y	N	Poor Wound Healing	Y	N
Bruising Tendency	Y	N	Respiratory Disease	Y	N
Cancer-Active	Y	N	Rheumatoid Arthritis	Y	N
Cancer-Remission	Y	N	Raynauds	Y	N
Cardiac Disorder	Y	N	Scleroderma	Y	N
Cold Sores	Y	N	Shingles	Y	N
Current Cold/Flu	Y	N	Sjogrens	Y	N
Diabetes	Y	N	Skin Rash currently	Y	N
Epilepsy/Seizures	Y	N	Staph Infection/MRSA	Y	N
Hepatitis Type __	Y	N	Stroke	Y	N
High Blood Pressure	Y	N	Thyroid Disorder	Y	N
High Cholesterol	Y	N			
HIV	Y	N			
Infection currently	Y	N			
Kidney Disease	Y	N			
Leukopenia	Y	N			
Liver Disease	Y	N			
Low Blood Pressure	Y	N			

Please list any other conditions:_____
_____

If you answered YES, to any of the above questions, please state how this medical condition is being managed. Name of Physician, Name of Medication, other treatment, etc.

_____
_____

Current Medical History:
Please state the reason(s) for your visit and describe any symptoms you are experiencing:

____

____

Please list any relevant family history:____

Hospitalizations/Surgeries (including tonsils, gallbladder, appendix, cosmetic):

Procedure	Year

Medications/Supplements:

Name	Reason for taking	Date Began	Dosage

Are you currently taking any "blood thinning" medications? ____ Yes or ____ No
Are you currently taking any antibiotics? ____ Yes or ____ No

Please check if presently using any of the following (please check all that apply):
___ Accutane ___ Glycolic Acid/Alpha Hydroxy Acid ___ Topical Vitamin C ___ Vitamin A ___ Fish Oil
___ Hydroquinone ___ Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin

Have you had any allergic reaction to the following?

Local anesthetics (ex: lidocaine)	Y	N
Penicillin or other antibiotics	Y	N
Sulfa drugs	Y	N
Latex	Y	N
Sedatives	Y	N
Iodine	Y	N
Aspirin	Y	N
Drugs	Y	N
Any skin or cosmetic product	Y	N

If yes, please explain:____

____

Indicate Yes (Y), No (N) or Past (P) regarding use of the following:
Steroids: Y N P If yes, for what condition and dosage? ______________________________
Smoking: Y N P If yes, for how much per day? ______________________________
*Please be aware smoking in any amount compromises the healing process and may negatively affect the outcome of your treatment.
Analgesics: Y N P Caffeine: Y N P If yes, how many ounces per day: ______________________
Alcohol: Y N P If yes, how much per week? ____________ Recreational Drugs: Y N P
Female Clients: Are you currently pregnant or breast feeding? ____ Yes or ____ No

I attest that the above information is accurate to my knowledge and will alert Revive Med Spa and Regenerative Medicine if any information about my health changes.

Client Signature:____Date: ____________
Witness Signature:____Date:____________