



Name:	Date:	Occupation:		
Address:	Phone:	Date of Birth:		
City:	State:	Zip Code:		
Cell: Phone:	Contact me by <input type="checkbox"/> Text <input type="checkbox"/> Cell	Emergency Contact:		
How did you hear about us:		Referral Name:		
<b>General Health</b>				
1. Rate your level of stress: (5 = highest, 1= lowest)    5    4    3    2    1				
2. Are you pregnant or nursing?    Yes    No				
3. Do you wear contact lenses?    Yes    No				
4. Do you smoke?    Yes    No    How many cigarettes per day?				
5. Please list any accidents or surgeries in the last 9 months:				
6. Do you have any metal implants, a pacemaker or body piercings?				
7. List the medications you are currently taking:				
Prescription		Over the Counter		
<b>Health History</b>				
Heart Condition	lymph Edema	Herpes/Shingles	High Blood Pressure	Low
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain	
Rashes	Jaw Pain/TMJ	Blood Clots	Constipation	
Diabetes	Gas/Bloating	Headaches	Arthritis	
Broken/Fractured Bones	Pregnancy ( ___ weeks)	Fatigue/Sleep Disorder	Depression/Anxiety	
Other (explain): Undergoing Cancer treatment				
<b>Skin Care</b>				
1. Are you under the care of a dermatologist?    Yes    No				
2. Do you use:    Accutane    Retin A    Renova    Adapalene    Other prescription skin products _____				
3. Have you had a:    Chemical Peel    Microdermabrasion    Botox    Other resurfacing treatments				
4. Are you currently using any products that contain:    Glycolic Acid    Lactic Acid    Hydroxy Acid    Vitamin A				
5. Do you have any skin sensitivities or irritants				
<b>Skin Maintenance</b>				

Products You Use: Masque	Soap	Cleanser	Toner	Moisturizer	Exfoliator
Skin Type:	Oily/Congested	Dry/Dehydrated	Sensitive/Redness	Acne	Sunburned
Eczema	Claustrophobia	Psoriasis	Iodine or Shellfish		
Have you been tanning in the last 24 hours?	Yes	No	Are you going or coming from a vacation?	Yes	No
What are your skin care goals?					

It is my choice to receive these Services from Carelife Style Medical Aesthetics. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update the staff at Carelife Style Medical Aesthetics of any changes to my health status.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24hour notice, I agree to pay the missed appointment fee that applies.

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Name

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Date