SKIN CARE SOLUTIONS

MEDICAL HISTORY

(Patient is responsible for providing any necessary changes to this form)

Name_____ Date_____

Address_____

City_____ State_____ Zip _____

Date of Birth_____ Circle: Male or Female?

Email_____

Cell Phone_____ Home Phone _____

Please circle your preferred contact method: Cell Home Email Text

If you wish to be contacted via text for appointment confirmations, follow up's, etc. please initial for permission:_____

Emergency Contact Name and Number_____

How did you hear about us?_____

Client History: Have you had any of the following, past or present? Please Circle

Pacemaker	Vitiligo
Keloids	Atypical Moles
Melanoma	Seizures
Reynaud's Syndrome	Heart Disease
Bleeding Disorder	HIV/AIDS
Metal Implants	Epilepsy
Cancer/Cancerous Lesions	Cold Sores

Women Only:
Are you pregnant, trying to get pregnant or breastfeeding? _____
Are you currently taking birth control?_____

List any medical conditions, health concerns or surgeries you have or have had

_____

_____

List any prescriptions or over-the-counter medications you are currently taking

_____

_____

List any allergic reactions to oral or topical medicines and/or products, including LATEX and any numbing products as well as any food allergies

_____

_____

Tell us how we can assist you today: Circle **ALL** concerns that apply:

Skin Care: Antiaging, Chemical Peels, Microdermabrasion, Rosacea, Acne, Deep Pore Cleansing, Age Spots, Facial Waxing, Hyperpigmentation

Facial Rejuvenation: Fillers, Botox, Laser, Neck/Jowl Treatments, Frown Lines, Crows Feet, Wrinkles/Fine Lines, Volume Loss

Body Contouring: Fat Reduction, Tissue Tightening, Cellulite Reduction, "Crepey" Arms, Stretch Marks

Briefly explain your main concerns:_____

_____

Please circle any procedures you have had and write where/ when you have had procedure

Botox Dysport Xeomin Juvederm Voluma Radiesse Belotero
Restylane/Perlane Sculptra CoolSculpting Venus Legacy

_____

Have you had any plastic surgery/cosmetic procedures? If so, when and where?_____

Do you wear sunscreen?_____ Are you planning vacation in sun soon?_____

Do you have tendency to facial redness or flushing?_____ Do you smoke?_____

Have you ever tanned in tanning bed?_____ or been a lifeguard?_____

What brand of skincare products are you currently using _____

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. I represent to the physicians and staff at SCS that I am at least 18 years of age, or if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and/or assistant or staff as may be assigned by him/her.

I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize and consent to be photographed for the purpose of my permanent record and for advertisement or display purposes. I understand that my email and cell phone number may be used to inform me of periodic special events and/or promotions and I consent to same.

Accepted and Agreed:_____ Date _____
SCS Consultant's Initials _____ Date _____