cma | Center for Modern Aesthetic Medicine

Personal Information

Last Name_____First Name_____M.I._____

Street Address_____

City_____State_____Zip Code_____

Phone Number_____Alternate Phone_____

E-mail Address_____

Date of Birth_____/_____/_____ Sex: M_____F_____

Occupation_____ Company Name_____

Emergency Contact_____ Relationship _____

Phone Number_____

Referred by: (please check all that apply)

_____Radio Ad
_____Internet Search
_____Magazine Ad
_____Physician Referral
_____Friend/Family Member – Name:_____

Medical History

Cold Sores/HSV (Please Circle): YES OR NO

Patients with a history of cold sores are at risk of re-occurrence when having laser treatments done. Please notify us of ANY history so we can take measures to prevent re-occurrence.

Have you ever had, or been treated for any of the following (check all that apply)?

_____Epilepsy	_____Allergy/Hay Fever	_____Dizziness/Fainting Spells
_____Skin Rash	_____Hepatitis	_____High Blood Pressure
_____Head Injury	_____Eye Problems	_____Heart Trouble
_____Lung Trouble	_____Neuritis	_____Cancer
_____Tuberculosis	_____Rheumatism/Arthritis	_____Diabetes
_____Varicose Veins	_____Tendonitis	_____Phlebitis of Vein
_____Fever/Sweats	_____HIV	_____Bruise Easily
_____Back Pain	_____Headaches	_____Unexplained Weakness
_____Anxiety/Stress	_____Bleeding Problems	_____Muscle/Joint Pain
_____Nausea	_____Ankle/Feet Swelling	_____Unexplained Weight Fluctuation
_____Vomiting	_____Diarrhea	_____Depressed Immune System

Are you currently under medical treatment for other conditions? _____

If yes, please explain_____

Do you have any allergic reactions to any medications, i.e. lidocaine, eggs/albumin, etc.?
_____

If yes please list_____

Do you have latex allergies? _____ Do you have tape allergies? _____

Do you have any allergic reactions to any products, i.e. aloe, lavender, etc.? _____

If yes please list_____

Are you taking any medications or vitamins? _____

If yes please list_____

Please answer yes or no to the following questions:

Do you smoke? _____If yes how much? _____

Do you drink alcohol? _____ If yes how often? _____

Do you use recreational drugs? _____ If yes what kind? _____

Female patients

Are you pregnant or planning on becoming pregnant at this time? _____

When was your last menstrual period? _____

Are you breastfeeding? _____

Please list any and all medical/surgical procedures:

Procedure:_____Date:_____

Procedure:_____Date:_____

Procedure:_____Date:_____

Skincare

Do you currently follow a skincare regimen? _____ If yes what products are you currently using?

Cleanser _____

Exfoliant/Scrub_____

Toner_____

Serum _____

Moisturizer_____

Sunscreen_____

How much time do you spend in the sun? _____

How often do you reapply sunscreen? _____

What makeup/foundation are you currently using?_____

What is your skin like on a day to day basis? Normal , Oily , Dry, Or Combination

Do you use tanning booths?_____ Do you use self tanners?_____

Skin Type: Caucasian_____African-American_____Hispanic_____Asian_____Other_____

What are your areas of concern? (Check all that apply)

Face:

- [ ] Skin Laxity
- [ ] Dullness
- [ ] Oiliness
- [ ] Wrinkles
- [ ] Rough skin texture
- [ ] Dryness
- [ ] Acne/Large Pores
- [ ] Redness
- [ ] Veins
- [ ] Pigmentation
- [ ] Thinning Lips
- [ ] Scarring

Body:

- [ ] Scars
- [ ] Unwanted Body Hair
- [ ] Leg Veins
- [ ] Stretch Marks
- [ ] Tattoo Removal
- [ ] Toenail Fungus
- [ ] Body Sculpting
- [ ] Cellulite
- [ ] Plantar Fasciitis
- [ ] Localized Fat
- [ ] Chest/Hand Antiaging
- [ ] Skin Texture

Women's Health:

- [ ] Do you leak urine when you cough, sneeze, or exercise?
- [ ] Do you wake up in the middle of the night to use the restroom?
- [ ] Do you experience dryness, itchiness, and/or discomfort?
- [ ] Are you interested in Vaginal Rejuvenation?