Medical History Form

Date: _____ Birth Date: _____

Name: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell phone: _____

Email: _____

How did you hear about us? _____

Have you seen a Dermatologist in the past year? ____YES ____ NO
If yes, list Dermatologist's name, contact info and reason for visit:_____
_____

Are you now or have you been under the care of physician within the last two years? ____YES ____NO
If yes, please provide the physician's name and phone number: _____
_____

List all medications you are taking, including the use of topicals like RetinA, Glycolic Acid & Acutane:
_____

Are you using eye drops or other ocular medications? _____

Are you taking Aspirin, Ibuprofen, Warfarin or Plavix? _____

ALLERGIES: List any drug; make up, skin or food allergies (i.e. soaps, lotions, cleansing creams, latex, etc)
_____

Have you recently had any laser treatments or skin peels? _____

Have you had Botox? If so, when: _____ area injected: _____

Have you had Fillers? If so, when: _____ area injected: _____

When was your last lengthy exposure to the sun? _____ tanning booth? _____

Do you use self tanning or auto bronzing products? _____

Do you tweeze, wax, sugar, thread or use hair removal cream? _____

What type of skincare are you using at home? _____

Do you use a sunscreen? ____YES ____NO____Sometimes

Are you claustrophobic? ____YES ____NO

Do you any of the following conditions concern you?
Check all that apply

□ Corneal Abrasions
□ Cataracts or Glaucoma
□ Blepharoplasty (eyelid surgery)
□ Eye Surgery or Injury
□ "Dry Eye"
□ Mascular Degeneration
□ Do you wear contact lenses?
□ Visual Disturbances
□ Breathing problems
□ Herpes
□ Circulation Problems
□ Prolonged Breathing
□ Hemophilia
□ Abnormal Heart Condition
□ High or Low Blood Pressure
□ Neurological Disorders
□ Epilepsy
□ Cancer _____
□ Chemotherapy / Radiation
□ Tumors/Growths/Cysts
□ Diabetes
□ Hepatitis
□ HIV
□ Abnormal wound healing
□ History of Keloid Scarring?
□ Cold Sores / Fever Blisters
□ Acne / Active / History of Scarring
□ Hypo pigmentation (lightening)
□ Hyperpigmentation (darkening)
□ Melasma
□ varicose veins / spider veins
□ Blood Clots / Deep vein thrombosis
□ Ruptured Varix (bleeding varicose vein)
□ Venous Stasis Ulcers (vein ulcer)
□ Leg pain, severe & persistent
□ Edema (swelling)
□ Recurrent Infections
□ MRSA
□ History of Cosmetic Surgery
□ Laser Surgery or treatment
□ Bariatric Surgery
□ Vascular/Vein Surgery
□ Sclerotherapy
□ Heart Surgery
□ Mental Health Issues
□ Tattoos / Body Modifications
□ History of any Implants?
□ Heart Valve Replacement / Repair
□ Prosthetic devices in your body?
□ Are you pregnant? Nursing?
□ Do you use tobacco products?

List any conditions not mentioned above: _____
_____

Please indicate services or areas for which you are interested in:

□ Sun Spots/Brown Spots
□ Wrinkles Reduction
□ Varicose Veins/Spider Veins
□ Facials, Microderms
□ Hair Removal
□ Active Acne/Acne Scarring
□ Healthy Makeup Options
□ Anti-Aging Supplement
□ Ideal Protein/Weight Loss
□ Botox and/or Fillers
□ Skin Tighten
□ MicroLaser Peel
□ Body Treatments
□ Skin Analysis
□ Rosacea
□ Obagi Skin Care
□ Current Skin Care Product Analysis
□ Other _____

Additional Comments: _____
_____

Would you like to learn how earn an extra $25.00 towards your next service? ____YES ____NO

Would you like to learn about our last minute club? ___YES ___NO / Eternal Club? ___YES ___NO

Any Suggestions for us? _____
_____

On this day I have freely and truthfully submitted my medical information. I have been given information regarding HIPPA. I understand it is my responsibility to report any updates or changes in my medical condition/s to Eterna MedSpa employee/s or Health Care Provider prior to receiving any treatment/s or procedures.

Client Name (Print): _____
Client Signature: _____ Date: _____