Empower MedSpa

Patient Information

Date ____/_____/_____

Name (First)_____ (Last)_____ (MI)_____

Address_____

City_____ State_____ Zip_____

Email Address_____

Preferred Phone Number_____ Cell / Home May we leave a message? YES NO

Preferred method of communication from our office? (please circle all that apply) TEXT PHONE CALL EMAIL

Date of Birth _____/_____/_____ Age_____ Sex M / F Marital Status_____

Occupation_____ Employer_____

Emergency Contact Name_____

Relationship_____ Phone Number_____

How did you hear about us_____

Reason for consultation today_____

Please describe your skin and skin concerns by checking all that apply:

___ Thick	___ Dry	___ Active Acne	___ Sallow
___ Thin	___ Normal	___ Acne Scars/Scars	___ Puffiness
___ Saggy	___ Oily	___ Blackheads/Whiteheads	___ Rosacea
___ Firm	___ Combination	___ Cysts	___ Dehydrated
___ Fine lines	___ Large Pores	___ Dark spots/Patches	___ Eczema or Psoriasis
___ Wrinkled	___ Sun Freckles	___ Scaling/Flaking	___Dark Circles/Eyes
___ Aging	___ Uneven/Blotchy	___ Broken Capillaries	___ Other_____

Are there any other treatments/conditions you are interested in hearing more about? (please circle all that apply)

LONGER EYELASHES	DOUBLE CHIN
DARK SPOTS/HYPERPIGMENTATION	FINE LINES AND WRINKLES
EXCESSIVE SWEATING	SKIN LAXITY
THINNING HAIR	MEDICAL GRADE SKIN CARE
VAGINAL REJUVENATION	ACNE
SCAR TREATMENT	HAIR REMOVAL

Other_____

What is important to you when deciding on a treatment?_____

SKIN CARE

With what temperature water do you cleanse? ☐ Cool ☐ Warm ☐ Hot

Do you have any special skin problems pertaining to your face and body? ☐ Yes ☐ No

If yes, please specify _____

Do you experience irritation from shaving? ☐ Yes ☐ No Do you experience ingrown hairs? ☐ Yes☐ No

For unwanted hair do you ☐ wax, ☐ pluck or ☐ have electrolysis?

What skin care products are you currently using?

☐ soap ☐ cleanser ☐ toner ☐ moisturizer ☐ masque ☐ exfoliator ☐ eye products ☐ sunscreen ☐ shaving products ☐ prescription skin care product ☐ acne products ☐ foundation ☐ skin lighteners ☐ Others

_____

What brand name(s) to do you use?

_____

What spf sunscreen do you use on your face? _____ body? _____

Have you had any recent sun exposure in the past 4-6 weeks, including tanning beds, bronzing creams or spray tans?

If so, please specify_____

Are you using Retin-A, Hydroquinone (bleaching cream), glycolic acid, Accutane or any other medication that could cause sun sensitivity? ☐Y☐N

If yes, please explain_____

NERVE ACTIVITY

What is your pain threshold? ☐ Low ☐ Medium ☐ High

Have you ever experienced claustrophobia? ☐ Yes ☐ No

Do you ever experience a burning, itching sensation on your skin? ☐ Yes ☐ No

Have you ever had a reaction to any of the following cosmetic ingredients? ☐ progesterone

☐ aloe vera ☐ hydroquinone ☐ benzoyl peroxide ☐ sulfur ☐ glycolic ☐ cortisone

☐ vitamin C (L-Ascorbic Acid) ☐ sunscreens ☐ other_____

Please fill out as completely as you are able. All information will be held in strict confidence.

MEDICAL HISTORY

Are you currently under the care of a physician? YES / NO

If yes, for what reason(s)?_____

Name of Physician_____ Office Phone_____

Illnesses (past five years): _____

Chronic Problems:_____

_____

Surgery, (incl. cosmetic): _____

_____

Do you faint easily? ☐Y☐N Do you scar easily? ☐Y☐N

Allergies:

Have you ever had a reaction to any of the following? ☐food ☐medicine ☐cosmetics ☐pollen ☐animals

☐fragrance ☐aspirin ☐ latex ☐'caine' medications **Please specify**:_____

_____

Have you ever had a reaction or complication from the numbing medication at the dentist? ☐Y☐N

If yes, please explain_____

Drug Therapy (please circle all that apply)

CHEMOTHERAPY BLOOD THINNERS HERBAL THERAPY STEROIDS DIET AIDES ACCUTANE

Please list any **prescribed** or **over the counter oral or topical medications** you are currently using, including: *allergy medications*, *acne treatments*, *Aspirin***,** *Ibuprofen, herbs &* ***vitamin****s*: _____

_____

Pharmacy Name_____ Phone Number_____

Are you currently seeing a dermatologist? ☐Y☐N Any diagnosed condition(s)? ☐Y☐N

If yes, please explain_____

Dermatologist Name_____ Phone Number_____

When was the date of your last dermatologist check up?_____

Have you ever had a chemical peel? ☐Y☐N

Last treatment date:_____ Area treated_____

Have you recently had microdermabrasion? ☐Y☐N

Last treatment date:_____ Area treated_____

Have you ever had any laser or photofacial treatments in the past? ☐Y☐N

Last treatment date:_____ Area treated_____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin), keloid scars or marks/scars from physical trauma, chicken pox or acne? ☐Y☐N

If so, please describe_____

Do you have any permanent cosmetic tattoos?

Last treatment date:_____ Area treated_____

Have you ever had Botox® or Dysport® injections?

Last treatment date:_____ Area treated_____

Have you had previous dermal filler, Kybella™or Sculptra® injections?

Last treatment date_____ Area treated_____

Do you have or have you ever had any of the following?

Freckles, moles or skin conditions that have caused concern and/or have been treated? ☐Y☐N

If yes, where_____

Veneers on your teeth? ☐Y☐N

Frequent or occasional cold sores to mouth or genitalia?☐Y☐N

Herpes? ☐Y☐

Skin conditions? (i.e. vitiligo, eczema, psoriasis, melasma, allergic dermatitis) ☐Y☐N

If yes, what and where?_____

Facial numbness? ☐Y☐N

Eye conditions? (i.e. glaucoma, excessive tearing, macular degeneration, Leber's hereditary optic neuropathy, blindness)

If so, please explain_____

Epilepsy/seizures? ☐Y☐N

Bell's Palsy? ☐Y☐N If so, what age and/or circumstance_____

TIA/Stroke? ☐Y☐N

Is your immune system compromised in any way? (i.e. HIV, AIDS, chronic steroids, chemotherapy) ☐Y☐N

If yes, how so?_____

Lambert-Eaton Syndrome? ☐Y☐N

Myasthenia Gravis? ☐Y☐N

Lupus? ☐Y☐N

Multiple Sclerosis? ☐Y☐N

Amyotropic Lateral Sclerosis (ALS)? ☐Y☐N

Collagen diseases such as Ehlers-Danlos or scleroderma? ☐Y☐N

Blood clotting disorders? ☐Y☐N

Diabetes? ☐Y☐N

Hormone Imbalance? ☐Y☐N

Thyroid Condition? ☐Y☐N

Migraines? ☐Y☐N

Double vision? ☐Y☐N

Hepatitis? ☐Y☐N

Heart disease? (i.e. coronary disease, atrial fibrillation, valvular disease) ☐Y☐N

Do you have a pacemaker? ☐Y☐N

Cancer? ☐Y☐N

High Blood Pressure? ☐Y☐N

Parkinson's Disease? ☐Y☐N

Kidney or liver disease? ☐Y☐N

Any metal implants, pins or plates? ☐Y☐N Location_____

Any active infection? ☐Y☐N

Do you wear contact lenses? ☐ Yes ☐ No

Social History

Do you follow a restricted diet? ☐Y☐N

Exercise Habits/Frequency_____

Cigarette smoke ☐Y☐N _____ packs per day _____ years

Alcohol use ☐Y☐N _____ drinks per _____

Drug use ☐Y☐N If yes, please explain_____

Do you have regular sleep patterns? ☐Y☐N

Do you consume caffeinated products? ☐ Yes ☐ No If yes, please explain_____

For women only:

Could you be pregnant? ☐Y☐N Are you breastfeeding? ☐Y☐N

Are your menstrual cycles normal? ☐Y☐N

Birth Control Pills? ☐Y☐N Depo-Provera ☐Y☐N Date of last shot? ___/___/_____

Menopausal/peri menopausal hormone replacement therapy? ☐Y☐N

Periodic acne flare-ups related to cycle? ☐Y☐N

Please sign below, and thank you for your time!

Patient Signature_____ Date____/____/_____

Provider Signature_____ Date____/____/_____

Determining Skin Type

Genetic Disposition

Score	0	1	2	3	4
Eye Color	Lt Blue, Grey, Green	Blues, Grey Or Green	Blue	Dk. Brown	Brownish Black
Hair Color	Sandy Red	Blond	Chestnut/Dk Brown	Dk. Brown	Black
Skin Color (unexposed areas)	Reddish	Very Pale	Pale w/ Beige Tint	Lt. Brown	Dk. Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Total score for genetic disposition: _____

Reaction to Sun Exposure

Score	0	1	2	3	4
Prolonged Sun Exposure	Painful redness, blistering, peeling	Blistering then peeling	Burn then peeling	Rare burns	Never burn
What degree do you brown?	Hardly/not at all	Light tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you brown after several hours of sun?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Resistant	No problem

Total score for reaction to sun exposure: _____

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to ANY type of sun?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for tanning habits: _____

Add up the total scores for each section:

Total Score for genetic disposition: _____

Total Score for reaction to sun exposure: _____

Total Score for tanning habits: _____

Skin Type Grand Total Score: _____

Score: 0-7 **Type 1***: Very white or freckled skin and always burns*

Score: 8-16 **Type 2***: White skin and usually burns*

Score: 17-25 **Type 3***: White or olive skin and sometimes burns*

Score: 25-30 **Type 4***: Brown skin and rarely burns*

Score: Over 30 **Type 5**: *Dark brown skin and very rarely burns*

Score: Over 30 **Type 6**: *Black skin and never burns*