VITALIA MEDSPA

Client Name: _____ Date: _____

Date of Birth ___/___/____ Gender: M F Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____

Mobile: _____ Email: _____

How did you hear about Vitalia? _____

| | | | | | |
|---|---|---|---|---|---|
| | Oily Skin | | Cold Sores | | Skin Cancer (Self) |
| | Dry Skin | | Chronic Skin Conditions | | Skin Cancer in Family |
| | Combination Skin | | | | |
| | Chronic Acne | | Chemical Peel | | Laser Skin Resurfacing |
| | Keloid Or Hypertrophic Scar | | Recent Electrolysis or Threading (4-6 Wks) | | Accutane Use for Acne When? |
| | Recent Sunburn or Tan (Tanning Bed or Self-Applied) | | Recent Waxing or Plucking | | Recent Injection of Botox, Collagen, or Other Dermal Fillers |

2. When exposed to sun without sunblock or sunscreen do you usually:

___ Always burn, never tan ___Burn minimally, tan easily ___ Tan after initial burn

___ Burn easily, tan poorly ___Rarely burn, tan darkly easily ___Never burn, always tan

3. Do you use sunscreen regularly? _____

4. Do you use artificial or “sunless” tanning products? _____

5. Check any of the following areas of current interest/concern.

| | | | | | |
|---|---|---|---|---|---|
| | Sun Damage | | Acne | | Hair Removal |
| | Skin Tightening | | Rosacea | | Cellulite |
| | Clogged Pores | | Skin Discoloration | | Anti-Aging |
| | Wrinkles | | Skin Texture | | Dry skin |
| | Age Spots, Freckles | | Restorative Skin Care | | Oily skin |
| | Creating a healthy on-going skin care regime | | Vitamins/supplements to support healthy skin | | Make up that promotes healthy skin |

Primary Skin Concern: _____

_____

6. Do you take daily vitamins and supplements? _____

Name: _____

## Medical History

1. Please check all of the following that apply to you.

| | | |
|---|---|---|
| ___ Heart disease | ___ Diabetes | ___ Auto-immune disease |
| ___ Hypertension | ___ Hepatitis | ___ Have heart pacemaker |
| ___ Easy bleeding/bruising | ___ Endocrine/Hormonal disorder | ___ Wear contact lenses |
| ___ Delayed or abnormal wound healing | ___ Current or recent pregnancy | ___ Use tobacco products |

2. List any current medical problems: _____

_____

_____

3. List medications you currently take: _____

_____

_____

4. List any medication allergies: _____

_____

Are you allergic to latex? _____ Are you allergic to any metals? _____

5. History of Past Illnesses and Surgeries: _____

_____

_____

6. Emergency contact: _____ Relationship: _____

Contact Information: _____

I have been given an opportunity to read and review the "Notice of Privacy Practices."___ (Initials)

Client Signature: _____ Date: _____

Parent or Guardian (if client is under 18 years of age):

Signature: _____ Date: _____