**Live Well Aesthetics and Wellness**

**New Patient Paperwork**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact & Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your job require that you work outdoors? \_\_\_\_\_\_ No \_\_\_\_\_\_ Yes

Health History:

1. Have you been under the care of a physician, dermatologist or other medical professional in the past year?

□ No □Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any medication allergies? □ No □Yes If yes, please list allergy and severity:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List any medications are currently prescribed or taking, include supplements and over-the-counter medications:

|  |  |
| --- | --- |
| Medication Name: | Dose & Frequency: |
|  |  |
|  |  |
|  |  |
|  |  |

1. List all past surgeries and/or procedures, along with year preformed:

|  |  |
| --- | --- |
| Surgery and/or Procedure Name: | Year Performed: |
|  |  |
|  |  |
|  |  |
|  |  |

1. Do you smoke? □ No □Yes
2. Do you exercise regularly? □ No □Yes
3. Do you drink alcohol? □ No □Yes, If yes, how many drinks per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you have any metal implants or wear a pacemaker? □ No □Yes
5. Have you had any of these health conditions in the past or present?

*(please check all that apply and provide additional information in the space provided)*

Cancer □ Headaches □

Hormone Imbalance □ Hepatitis □

Systemic Disease □ Immune Disorders □

High Blood Pressure □ HIV/AIDS □

Spinal Injury □ Lupus □

Thyroid Condition □ Mental Bone Pins/Plates □

Hysterectomy □ Phlebitis □

Diabetes □ Blood Clots □

Heart Disease/Problems □ Psychological Treatment □

Varicose Veins □ Insomnia □

Arthritis □ Keloid Scarring □

Asthma □ Skin Disease/Skin Lesions □

Eczema □ Fever blisters/Cold Sores □

Epilepsy □ Any Active Infections □

Seizure Disorder □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □

1. Which of the following best describes your skin type?

*(Please circle one type number)*

I -- Creamy complexion: Always burns easily, never tans

II -- Light Complexion: Always burns, tans slightly

III -- Light/Matte Complexion: Burns moderately, tans gradually

IV -- Matte Complexion: Seldom burns, always tans well

V -- Brown Complexion :Rarely burns, deep tan

VI -- Black Complexion: Never burns, deeply pigmented

1. Any current or history of skin cancer?

□ No □Yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had any piercings, tattoos, or permanent cosmetics:

□ No □Yes, if yes, where?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_`

1. Do you have any special skin problems or concerns pertaining to your face or body? □ No □Yes

Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had chemical peels, laser or microdermabrasion in the last 1 month? □ No □Yes
2. Do you use Retin-A/Tretinoin or Retinol, Salicylic Acid, Lactic Acid, Vitamin C, Hydroquinone, Self-Tanning products? □ No □Yes

If Yes? Please explain which product and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Clients Only:**

Are you taking oral contraceptives? \_\_\_\_\_ No \_\_\_\_\_Yes

Yes? please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any recent changes to or from your contraceptive treatment? \_\_\_\_\_ No \_\_\_\_\_Yes

Yes? please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or trying to become pregnant? m No m Yes

Are you lactating? \_\_\_\_\_ No \_\_\_\_\_Yes

Any menopause problems or concerns? \_\_\_\_No \_\_\_Yes

Yes? please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you undergoing any hormone replacement therapy? \_\_\_\_No \_\_\_\_Yes

Yes? please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Future Appointments/Contact:**

May I call/text you at your home, work or cell phone number to confirm future appointments? □ No □Yes

May I contact you via mail/email about future promotions and news? □ No □Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure. I understand that withholding information or providing misinformation may result in contraindications and/or complications for aesthetic and wellness services and treatments received from Live Well Aesthetics and Wellness. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_