Nourished MedSpa and Wellness Center

Patient Information

Date: _____ Name: _____ Date of Birth: _____ Age: _____

Address: _____

Preferred telephone number: _____ Home / Work / Cell (circle one) Cell carrier: i.e., ATT/Verizon/Sprint

Ethnicity: _____ E-mail address: _____

Marital Status: Never Married or Single / Married / Divorced or Separated / Domestic Partnership / Widowed

If married, anniversary date: _____ Occupation: _____

Does your job require you to work outdoors? □ Yes □ No Do you wear sunscreen daily? □ Yes □ No

Emergency contact name: _____ Emergency contact number: _____

Emergency contact relationship to you: _____

How did you hear about us? Friend or word of mouth / Internet search / Promotion / Other: _____

Referred by: _____Primary care physician: _____

Including your visit today, which of the following issues concern you? (Check all that apply)

□ Lines/Wrinkles □ Aging skin □ Spider veins □ Acne/breakouts □ Spots or discolorations

□ Hair loss □ Unwanted hair □ Scars □ Deep furrows □ Unwanted tattoo(s)

□ Sweating □ Discolored nails □ Low energy □ Allergies □ Frown lines

□ Double chin □ Overweight □ Skin tags □ Cellulite □ Areas of excess body fat

□ Eczema/Rosacea □ Skin rejuvenation □ Erectile dysfunction □ Stretch marks □ "Gummy smile"

□ Sun damage □ Dull/dry skin □ Lip fullness □ Excessive oil/shine □ Uneven skin tone

Other: _____

What procedures interest you either now or sometime in the future? (Check all that apply)

□ Body shaping □ Chemical peel □ Botox/Xeomin □ Hydrafacial™ □ Dermal Fillers

□ IPL Photofacial □ Laser hair reduction □ Laser tattoo removal □ Spider vein / varicose vein removal

□ Microneedling □ Vampire Facial® □ B-12 injections □ Hair restoration □ Testosterone replacement

□ PRP Joint injection □ Allergy Testing □ Weight loss □ Female urinary incontinence treatment

□ PDO thread facelift □ Sexual enhancement □ Acne scar treatment □ Fat burning injection

□ IV fluid/vitamin infusions □ Laser Skin resurfacing □ Bioidentical hormone therapy

Have you ever had any of the following?

□ Botox/Xeomin/Dysport	□ Microdermabrasion	□ IPL therapy	□ Dermaplaning
□ Chemical peel	□ Dermal fillers	□ Chemical exfoliation	□ Microneedling
□ Laser hair removal	□ Massage	□ Body shaping	□ Laser tattoo removal
□ Laser Skin resurfacing	□ Skin tightening	□ Testosterone replacement	□ B-12 injections
□ Bioidentical hormone therapy		□ IV fluid/vitamin infusions	□ PDO threads placed

When were the above procedures performed and what products were used? _____

_____

In your own words, what would you like to achieve from your treatments?

_____

Have you ever had an allergic reaction to any of the following? (check any box that applies)

	No	Yes, **Mild** (rash, irritation, etc.)	Yes, **Moderate** (itching, vomiting, etc.)	Yes, **Anaphylaxis** (trouble breathing, throat closure, hives, etc.)
Cosmetics				
Food				
Animals				
Sunscreens				
Iodine				
Pollen				
Fragrance				
Shellfish				
Latex				
Medicines/drugs				
Alpha hydroxy acids				
Anesthetics				

Do you smoke? □ Yes □ No How much? _____ packs per day. I quit: □ Days □ Months □ Years ago

Do you drink alcohol? □ Yes □ No □ Daily □ Occasionally □ Rarely

Do you use drugs? □ Yes □ No □ THC

Patient Initial_____

List all medicine drug allergies:

Name	Yes, **Mild** (rash, irritation, etc.)	Yes, **Moderate** (itching, vomiting, etc.)	Yes, **Anaphylaxis** (trouble breathing, throat closure, hives, etc.)

List all medications and supplements (including over-the-counter vitamins, herbals or supplements:

Name and dose	**Schedule**
e.g., Lisinopril 10 mg	*Twice daily*

Please check any medical condition that you currently have or have had in the past:

□ High blood pressure	□ Diabetes	□ Lupus	□ Hepatitis
□ Heart problems	□ Claustrophobia	□ Asthma	□ Eczema
□ Psoriasis	□ Vitiligo	□ Keloids	□ Pacemaker
□ Metal implants	□ Seizures	□ Epilepsy	□ Anxiety
□ Depression	□ Thyroid problems	□ PCOS	□ Permanent makeup
□ Tattoos	□ MS	□ ALS	□ Bell's Palsy
□ Cold sores	□ Shingles	□ Varicose veins	□ Cancer
□ Immunosuppression	□ Poor wound healing	□ HIV	

Other: _____

Please list any and all surgeries:

□ Gall bladder	□ Appendix	□ Uterus	□ Ovaries
□ Heart	□ Intestines/Colon	□ Breast	□ Ortho (hip, knee, etc..)

Other: _____

Your Skin Care

	0	1	2	3	4
Eye Color	Light blue, light gray or light green	Blue, gray or green	Hazel or light brown	Dark brown	Brownish black
Natural Hair Color	Red or light blonde	Blonde	Dark blonde or light brown	Dark brown	Black
Natural skin color (before sun exposure)	Ivory white	Fair or pale	Fair to beige, with a golden undertone	Olive or light brown	Dark brown or black
How many freckles do you have on unexposed areas of your skin?	Many	Several	A few	Very few	None
How does your skin respond to the sun?	Always burns, blisters and peels	Often burns, blisters and peels	Burns moderately	Burns rarely, if at all	Never burns
Does your skin tan?	Never, I always burn	Seldom	Sometimes	Often	Always
How deeply do you tan?	Not at all or very little	Lightly	Moderately	Deeply	My skin is naturally dark
How sensitive is your face to the sun?	Very sensitive	Sensitive	Normal	Resistant	Very resistant/Never had a problem
Total					

☐ If you scored 0-6 points, you are a **Fitzpatrick Skin Type I**. You always burn and never tan in the sun. You are extremely susceptible to skin damage from the sun.

☐ If you scored 7-12 points, you are a **Type II**. You almost always burn, and rarely tan in the sun. You are highly susceptible to skin damage from the sun.

☐ If you scored 13-18 points, you are a **Type III**. You sometimes burn and sometimes tan in the sun.

☐ If you scored 19-24 points, you are a **Type IV**. You tend to tan easily and are less likely to burn in the sun.

☐ If you scored 25-30 points, you are a **Type V**. You tan easily and rarely burn in the sun.

☐ If you scored 31 or more points, you are a **Type VI**. You do not burn in the sun.**

Note that the closer you are to Type I, the more likely most laser treatments will safely and effectively treat your skin concerns. The closer you are to Type VI, some laser treatments may safely treat your skin concerns, however you may need to pursue other options for your skin type that are non-laser based including highly effective infrared and radio frequency treatments.

NOTE: If you have Asian, Native American, Middle Eastern, Latin America or Black ancestry, your skin type is considered Type VI regardless of the above criteria.

Do you currently use Retin-A, Renova, Hydroquinone, Hydroxyl Acid or Retinol/vitamin A derivative products?

□ Yes □ No Have you used any of the above products in the last 3 months? □ Yes □ No

Have you used an acne medication? □ Yes □ No, if so, when? _____ Type? _____

What skin care products are you currently using? (List brand) _____

Have you recently used any self-tanning lotions, creams or treatments? □ Yes □ No Please specify: _____

Do you wash your face daily? □ Yes □ No Do you exfoliate your skin? □ Yes □ No

Have you used any of the following hair removal methods in the past 4 weeks? *(Please check all that apply)*

□ Shaving □ Waxing □ Electrolysis □ Plucking / Tweezing □ Threading □ Depilatories □ Laser

If yes, where on your body? _____

Acne Questionnaire

How many years have you suffered from acne? _____

Where do you break out? □ Face □ Chest □ Back □ Other _____

What kind of breakouts do you get? □ Blackheads □ Small whiteheads □ Large whiteheads □ Cysts

Do you turn red easily? □ Yes □ No Does your skin become dry easily? □ Yes □ No

Do you blush easily? □ Yes □ No Do you use makeup to conceal your acne? □ Yes □ No

Female Clients Only

Do you menstruate? □ Yes □ No

Are your periods regular? □ Yes □ No

Are you taking contraceptives? □ Yes □ No

Please specify: _____

Any recent changes to or from your contraceptive treatment? □ Yes □ No

If so, what and when: _____

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

Are you lactating? □ Yes □ No

Any menopause problems? □ Yes □ No

Please specify: _____

Are you undergoing any hormone replacement therapy? □ Yes □ No

Please specify: _____

Male Clients Only

Do you wake up with an erection? □ Yes □ No If not, are you concerned about erectile dysfunction? □ Yes □ No

What is your current shaving system? □ Wet shave □ Electric

Do you experience irritation from shaving? □ Yes □ No Ingrown hairs? □ Yes □ No

Is your hair thinning or hairline receding? □ Yes □ No

Are you experiencing symptoms of "male menopause" (i.e., depression, fatigue, weight gain, loss of libido)

□ Yes □ No

Future Appointments/Contact:

May we call or text your preferred phone number to confirm future appointments? □ Yes □ No

Please note standard text messaging rates may apply

May we contact you via email to confirm appointments and send our promotions? □ Yes □ No

You may opt out at any time

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from my treatment that may be irreversible and/or may be grounds for dismissal from the practice. The treatments I receive here are voluntary and I indemnify and release this institution, all employees and contractors from liability and assume full responsibility thereof.

_____ Date: _____

Patient Signature