

Last Name	First Name	Middle Name
Street Address		
City	State	Zip
Home Phone	Work	Cell
E-mail	Occupation	Date of Birth
Primary Care Physician		Phone
How did you hear about us?		

PLEASE SPECIFY YOUR GENETIC ORIGIN

African American
 Asian
 Caucasian
 Hispanic
 Mediterranean
 Native American
 Other: _____

FEMALES

Are you pregnant?	YES	NO
Are you breastfeeding?	YES	NO
Are you planning pregnancy during the course of your treatment?	YES	NO
During pregnancy did you develop hyperpigmentation or masking?	YES	NO
Do you have regular periods?	YES	NO
Are you going through menopause?	YES	NO

Please list all medications including prescription and over the counter drugs, vitamins, herbs, supplements below.

Are you using any medications purchased outside the USA?	YES	NO
Are you allergic to any medications, foods, products? If yes, please list below.	YES	NO

MEDICAL HISTORY: Please check all that apply

<input type="checkbox"/> Acne	<input type="checkbox"/> Endocrine disorders	<input type="checkbox"/> Hirsutism	<input type="checkbox"/> Polycystic ovary disease	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Filler injections	<input type="checkbox"/> Hormone replacement Rx	<input type="checkbox"/> Psychiatric Conditions/Depression	<input type="checkbox"/> Transplants
<input type="checkbox"/> BOTOX cosmetic	<input type="checkbox"/> Gold therapy	<input type="checkbox"/> Implants	<input type="checkbox"/> Psoriasis/Eczema	<input type="checkbox"/> Vitiligo
<input type="checkbox"/> Burns/Skin Grafts	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kaposi's sarcoma	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Cold sores/fever blisters
<input type="checkbox"/> Cardiac conditions	<input type="checkbox"/> Herpes	<input type="checkbox"/> Keloid scars	<input type="checkbox"/> Shingles	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Lupus erythematous	<input type="checkbox"/> Skin cancer	<input type="checkbox"/> Metal or other implants
<input type="checkbox"/> Diastasis Recti	<input type="checkbox"/> Hernia(s)	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Radiation/Chemotherapy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eating disorders	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Permanent makeup	<input type="checkbox"/> Tattoos	

List any cosmetic procedures or surgeries above.

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you currently being treated for any medical condition(s)? <i>If YES, please explain:</i>	YES	NO
2. Have you ever seen a physician regarding your skin?	YES	NO
3. Do you have any active skin diseases or infection in the area to be treated?	YES	NO
4. Do you have any skin allergies?	YES	NO
5. Have you had skin cancer or pre-cancerous lesions?	YES	NO
6. Do you have psoriasis/eczema in the area to be treated?	YES	NO
7. Are there any moles with hair in the area to be treated?	YES	NO
8. Are you allergic to latex, lidocaine, or any lotions?	YES	NO
9. Have you ever had surgery in the area to be treated?	YES	NO
10. Have a history of Diastasis Recti?	YES	NO
11. Have a history of Hernia/Hernia repair?	YES	NO
12. Have you any previous laser treatments or other skin treatments to the area to be treated? <i>Describe:</i>	YES	NO
13. Have you/are you using medications such as Accutane? <i>Date of last use:</i>	YES	NO
14. Are you using Retina-A, Renova, Differein, Tazorac? <i>Concentration _____%</i>	YES	NO
15. Are you using glycolic/AHA home care products?	YES	NO
16. What skin care products are you currently using? <i>Please list:</i>	YES	NO
17. Do you smoke?	YES	NO
18. Do you sunbathe? <i>If yes, when was your last exposure?</i>	YES	NO
19. Are you currently using, or have you used a tanning bed or self tanner? <i>If yes, when was your last exposure/use?</i>	YES	NO
20. Do you use sunblock?	YES	NO
21. Do you use depilatories or hot wax?	YES	NO
22. Does your skin remain discolored after healing from a cut?	YES	NO

PLEASE INDICATE WHICH OF THE FOLLOWING CONCERNS YOU HAVE ABOUT YOUR SKIN/BODY?

<input type="checkbox"/> Aged skin	<input type="checkbox"/> Sun damage	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Age spots	<input type="checkbox"/> Spider veins	<input type="checkbox"/> Dry / Sensitive skin
<input type="checkbox"/> Acne	<input type="checkbox"/> Enlarged pores	<input type="checkbox"/> Blackheads	<input type="checkbox"/> Texture	<input type="checkbox"/> Scars	<input type="checkbox"/> Double Chin
<input type="checkbox"/> Redness	<input type="checkbox"/> Wrinkles	<input type="checkbox"/> Whiteheads	<input type="checkbox"/> Melasma	<input type="checkbox"/> Uneven skin color	<input type="checkbox"/> Skin laxity
<input type="checkbox"/> Leg veins	<input type="checkbox"/> Hair removal	<input type="checkbox"/> Oily skin	<input type="checkbox"/> Cellulite	<input type="checkbox"/> Pigment changes	<input type="checkbox"/> Stubborn fat/pinchable fat

PLEASE INDICATE THE SERVICE(S) YOU ARE INTERESTED IN OR WOULD LIKE MORE INFORMATION ON:

<input type="checkbox"/> Laser skin rejuvenation	<input type="checkbox"/> Rosacea treatment	<input type="checkbox"/> Acne treatment	<input type="checkbox"/> Pigment treatment	<input type="checkbox"/> Filler injections	<input type="checkbox"/> Melasma
<input type="checkbox"/> Laser vein treatment	<input type="checkbox"/> Sun damage repair	<input type="checkbox"/> Age spot treatment	<input type="checkbox"/> Wrinkle treatment	<input type="checkbox"/> Redness/vessel	<input type="checkbox"/> Fat reduction/CoolSculpting
<input type="checkbox"/> Laser hair removal	<input type="checkbox"/> BOTOX cosmetic	<input type="checkbox"/> Skin tightening	<input type="checkbox"/> Scar treatment	<input type="checkbox"/> Skin resurfacing	<input type="checkbox"/> Other:

I confirm that the answers to the questionnaire are true and correct.

Client Signature _____ **Date** _____

Medical Professional's Signature _____ **Date** _____

Medical Director's Signature _____ **Date** _____

This form must be completed for all new clients. BOTOX is a registered trademark of Allergan, Inc. Each Sona MedSpa franchise location is independently owned and operated. Services vary by location.