New Client Form

Full Name	Gender ☐ Male ☐ Female
Date of Birth / /	Email @
Phone Number ☐ Mobile ☐ Work ☐ Home ( )	
Home Address City State Zipcode	
How Did You Hear About Us? ☐ Google ☐ Yelp ☐ Social Media ☐ Friend Referral ☐ Other, please specify:	

Emergency Contact

Name | Relationship | Contact Number

Cosmetic Treatment

What Is Your Concern Today?

How Long has this been going on?

Have You Ever Had Any Cosmetic Treatments Before? If Yes, list below

How Happy Are You With the Result?
☐ Excellent ☐ Very ☐ Moderate ☐ Not at all

How Do You Decide What Is the Right Option?
☐ Basic ☐ Comprehensive ☐ Nonsurgical ☐ Surgical

How Much Downtime?
☐ None ☐ One week ☐ Two weeks ☐ More Than 3 weeks

Are You Currently Pregnant and/or Breastfeeding?
☐ Yes ☐ No

Do You Plan On Travelling By Air within A Week of Your Visit?
☐ Yes ☐ No

Medical History

Please List Any Medication Allergies and/or Food Allergies

Are You Currently Under A Physician's Care for Any Condition? If so, please describe

Please Indicate Any Medication You Are Currently Taking (prescription and over the counter supplements)

Have You Undergone Any Surgery In The Past, Either Cosmetic or Medical? If so, please indicate procedure(s)

Medical History

Check ☐ you currently have or have had in the past year

GENERAL
☐ Chills ☐ Depression ☐ Dizziness ☐ Fainting ☐ Fever ☐ Forgetfulness ☐ Headache ☐ Loss of sleep
☐ Loss of weight ☐ Nervousness ☐ Numbness ☐ Sweats

GASTROINTESTINAL
☐ Appetite poor ☐ Bloating ☐ Bowel changes ☐ Constipation ☐ Diarrhea ☐ Excessive hunger ☐ Excessive thirst
☐ Gas ☐ Hemorrhoids ☐ Indigestion ☐ Nausea ☐ Rectal bleeding ☐ Stomach pain ☐ Vomiting ☐ Vomiting blood

EYE, EAR, NOSE, THROAT
☐ Bleeding gums ☐ Blurred Vision ☐ Crossed eyes ☐ Difficulty swallowing ☐ Double vision ☐ Ear ache ☐ Ear discharge
☐ Hay fever ☐ Hoarseness ☐ Loss of hearing ☐ Nosebleeds ☐ Persistent cough ☐ Ringing in ears ☐ Sinus problems
☐ Vision – Flashes ☐ Vision – Halos

GENITO-URINARY
☐ Blood in urine ☐ Frequent urination
☐ Lack of bladder control ☐ Painful urination

MUSCLE/JOINT/BONES Pain, numbness in
☐ Back ☐ Arms ☐ Feet ☐ Hand
☐ Hips ☐ Neck ☐ Legs ☐ Shoulders

CARDIOVASCULAR
☐ Chest pain ☐ High blood pressure ☐ Irregular heart beat ☐ Low blood pressure ☐ Poor Circulation
☐ Rapid heartbeat ☐ Swelling ankles ☐ Varicose veins

EXCESSIVE SWEATING
☐ Hands ☐ Feet ☐ Facial ☐ Underarms
☐ Other___________

PODIATRY
☐ Bunions ☐ Hammer toes ☐ Ingrown nail
☐ Corns, calluses, warts ☐ Other___________

WOMEN ONLY
☐ Abnormal pap smear ☐ Bleeding between periods ☐ Breast lump ☐ Extreme menstrual pain ☐ Hot flashes
☐ Nipple discharge ☐ Painful intercourse ☐ Vaginal discharge ☐ Other___________
Date of last period:__________ Date of last pap smear:_______ Have you had a mammogram? ☐ Yes ☐ No

HEALTH HABITS
☐ Caffeine________ ☐ Drugs___________
☐ Tobacco________ ☐ Other_____________

OCCUPATIONAL HABITS
☐ Stress ☐ Heavy Lifting ☐ Hazardous substances
☐ Other________________

CONDITIONS
☐ AIDS ☐ Chemical Dependency ☐ High cholesterol ☐ Prostate problem ☐ Alcoholism ☐ Chicken pox ☐ Mumps
☐ HIV positive ☐ Psychiatric Care ☐ Anemia ☐ Diabetes ☐ Kidney disease ☐ Rheumatic fever ☐ Anorexia
☐ Emphysema ☐ Liver disease ☐ Scarlet fever ☐ Appendicitis ☐ Epilepsy ☐ Measles ☐ Stroke ☐ Arthritis
☐ Glaucoma ☐ Migraine headaches ☐ Suicide attempt ☐ Asthma ☐ Goiter ☐ Miscarriage ☐ Thyroid problems
☐ Bleeding disorders ☐ Gonorrhea ☐ Mononucleosis ☐ Tonsillitis ☐ Breast lump ☐ Gout ☐ Multiple sclerosis
☐ Tuberculosis ☐ Bronchitis ☐ Heart Disease ☐ Typhoid fever ☐ Bulimia ☐ Hepatitis ☐ Pacemaker ☐ Ulcers
☐ Cancer ☐ Hernia ☐ Pneumonia ☐ Vaginal infections ☐ Cataracts ☐ Herpes ☐ Polio ☐ Venereal disease

I hereby certify that the above information is correct to the best of my knowledge. I will not hold any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

I further understand that I have not entered a doctor patient relationship until further document completion and evaluation by a physician.

Patient Signature ______________________________ Date ______________________________