Dr. Steven C Spencer
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MEDICAL/COSMETIC HISTORY

Name:_____ Date:_____
Date of Birth:___/___/___ Age:____ Occupation:_____
Phone numbers: (H)_____ (C)_____ (W)_____
Email:_____
Address: _____ City/State_____ Zip:____

REASON FOR TODAY'S VISIT: _____

How did you learn of About Face & Body?_____

LIST ALL CURRENT MEDICATIONS:
Include prescriptions, over-the-counter medications, and supplements (both oral and topical.)
1._____ 4. _____
2._____ 5. _____
3._____ 6. _____

Have you taken Accutane (isotretinoin)? Yes/No If Yes, when?_____
Do you have any allergies? (medications, food, products, etc) Yes/No
If yes, list and describe reaction:_____
_____
Do you have Herpes Simplex or Cold Sores? Yes/No
Reactions to adhesives, latex or bandages? Yes/No If yes,
explain:_____
Have you ever had a reaction to local anesthesia (including dental)? Yes/No If yes,
explain: _____
Have you been on blood thinners, aspirin or have a history of a bleeding disorder?
Yes/No If yes, please explain: _____
Are you currently under the care of a dermatologist? If so, please describe._____
Have you ever noticed darkening of scars or "hyperpigmentation" after injury to the skin or in areas of repeated trauma or friction? If so, please explain.
_____
_____

SKIN: Please check if you have had any of the following:

__Actinic Keratosis __Skin Cancer (if so, type)_____
__Abnormal Moles __Acne __Rosacea __ Keloid Scarring
__Abnormal Pigment __Rashes __Psoriasis __Eczema
__Excessive Sweating __Skin Infections __Severe sunburn
__Very sensitive skin __Severely dry skin __Skin infections

MEDICAL HISTORY: Please check if you have had any of the following:

__Asthma __Breathing problems __Chronic Bronchitis
__Tuberculosis __Heart attack __High Blood Pressure
__Irregular heartbeat __Phlebitis/blood clots __Pacemaker
__Defibrillator __Epilepsy/seizures __Diabetes
__Low Blood Sugar __Thyroid Disorder __Fainting
__Dialysis __Kidney Disease __Hepatitis
__Cancer __Organ transplant __Lupus
__HIV/AIDS __Arthritis __Artificial Joint
__Clotting disorder __Slow healing __Dental Implants

Have you ever been hospitalized? Yes/No. If so, explain:
_____
Have you ever had major surgery?: Yes/No. If so, explain:
_____
Have you had a serious injury or illness in the past year? Yes/No. If so, explain:_____
Do you smoke cigarettes? Yes/No. If yes, # packs per day?_____
Do you drink alcohol? Yes/No. If yes, # of ____ drinks per week.

Women:

Are you pregnant or nursing? Yes/No.
Are you planning to become pregnant? Yes/No. If yes, how soon?_____
Are you now having regular periods? Yes/No. If no, please explain:_____
Are you on hormonal therapy? Yes/No. If yes, please explain:
_____
Please list any cosmetic treatments you have had in your history:
_____
_____

Please check if you have any of the following concerns:

__ Uneven pigmentation
__ Lines around Nose or Mouth
__ Sagging Skin
__ Broken Blood Vessels – Face
__ Varicose Veins
__ Oily Skin
__ Flushing/Red or Ruddy Skin
__ Large Pores
__ Skin Tags or Moles
__ Stretch Marks
__ Thin Lips
__ Sun damaged skin
__ Eyelashes: Longer/Fuller/Darker?
__ Fine Lines or Wrinkles
__ Dark Circles/Puffiness of Eye Area
__ Brown Spots
__ Spider Veins
__ Unwanted Hair
__ Active Acne
__ Rough/Coarse Skin
__ Oily Skin
__ Acne Scars
__ Scars
__ Jowls
__ Flabby arms
__ Cellulite
__ Problem areas of fat storage not improved by diet or exercise

Other concerns not listed above? _____
_____

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.		
Younger Than	True Age	Older Than
When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles		
Not Concerned	Somewhat Concerned	Very Concerned

I understand that after I sign this waiver, I agree to inform the provider/staff with ANY changes pertaining to the above questionnaire prior to any future treatments. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history now and in the future. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that payment is due at time of all services and products. There are NO REFUNDS on any services.

Client Signature:_____ Date:_____