Ageless Center
MEDICAL WEIGHTLOSS & MEDSPA

Personal History:

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex (M/F): _____ Race: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Carrier: _____
Email: _____
Employer: _____Occupation: _____ Work Phone: _____
Emergency Contact Name and Phone: _____
How Did You Hear About Ageless? PLEASE CHECK ONE: BE SPECIFIC

- ☐ Physician Referral Name: _____
- ☐ Client Referral Name: _____
- ☐ TV Station Name: _____
- ☐ Radio Station Name: _____
- ☐ Print Name: _____
- ☐ Social Media Explain: _____
- ☐ Event/Health Fair Explain: _____
- ☐ Other Explain: _____

Briefly describe your treatment interest: _____
_____

Skin Type Information:

Which type of the following best describes your skin response to the sun? (Please check only ONE type)

____ Always Burns, Never Tans ____ Always Burns, Sometimes Tans ____ Rarely Burns, Always Tans
____ Sometimes Burns, Always Tan ____ Brown, Moderately Pigmented Skin ____ Black Skin

Which of the following best describes your skin type? (Please check only ONE type)

____ Normal ____ Dry ____Sensitive ____Oily ____Combination: If so, explain _____

Which of the following best describes your facial complexion? (Please check all that apply)

____ Age Spots ____ Freckles ____Uneven Skin Tone ____ Whiteheads
____ Rough Texture ____ Blackheads ____ Spider Veins/Red Spots ____ Acne
____ Scars ____ Wrinkles/Fine Lines ____ Enlarged Pores

Skin Care Products:

Please list all products/brands you are currently using:

Moisturizer _____ Cleanser _____
Mask/Scrub _____ Toner/Astringent _____
Eye Cream _____ Topical Treatments/Meds _____
Makeup _____ Sunscreen _____
Other _____

Medical History:

Are you currently under the care of a physician? ____ Yes ____ No
Are you currently under the care of a dermatologist? ____Yes ____ No
Do you have an autoimmune disease? ____ Yes ____ No If yes, please explain_____

Do you have any of the following medical conditions? (Please check all that apply)

____ Cancer ____ Cold Sores ____ Lupus ____ Herpes ____ High Blood Pressure
____ Arthritis ____ HIV/AIDS ____ Hepatitis ____ Rosacea ____ Hormone Imbalance
____ Psoriasis ____ Eczema ____ Thyroid Imbalance ____ Blood Clotting Abnormalities
____ Seizure Disorder ____ Keloid Scarring ____Any Active Infection ____ Skin Disease/Skin Lesions

Do you have any other health problems or medical conditions? (Please List) _____
_____

What medications **or** over-the-counter drugs are you presently taking? (Please check all that apply)

____ Birth Control Pills ____ Hormones ____ Antibiotics ____ Steroids
Vitamins/ Herbs (Please List) _____
Others (Please List) _____
What topical medications are you currently using? _____
Do any of the above medications make you photosensitive? _____
Have you ever used Accutane? ____ Yes ____ No If so, when? _____
Have you ever used Renova, Retin-A, Tazorac, Avita? ___Yes ___No If so, when? _____
Have you ever used glycolic, lactic or salicylic acid products? ___Yes ___ No If so, when? _____
Have you ever had any of the following? (Please check all that apply)

____ Facial Surgery ____ Dermal Fillers ____ Botox® or other neurotoxin ____ Chemical Peels
____ Laser Resurfacing ____ Laser Hair Removal ____ Microdermabrasion ____ Other

Other: Explain _____
When? _____

Have you used any of the following to treat unwanted hair? (Please check all that apply)

____Shaving ____Depilatory/ Bleaching Creams ____Waxing ____Electrolysis ____Vaniqa®
____Tweezing ____Laser: If so, when? _____

Do you form thick or raised scars from cuts or burns? ____Yes ____No
Do you have hyper pigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin) or marks after physical trauma? ____Yes ____No If yes, please explain: _____
Are you undergoing chemo or radiation therapy? ____Yes ____No If yes, explain: _____
Have you recently used any self-tanning lotions or treatments? ____Yes ____No If yes, explain: _____
Do you wear sunscreens? ____Yes ____ No How Often? _____ SPF_____

Females:

Are you pregnant? ____ Yes ____No Planning to become pregnant? ____Yes ____No
Are you using contraception? ____Yes ____No Are you breastfeeding? ____Yes ____No

Allergies:

Have you ever had any allergic reaction to any of the following? (Please check all that apply)

____Food ____Latex ____Cosmetics ____Aspirin ____Other
____Lidocaine ____Hydrocortisone ____Hydroquinone/Skin Bleaching Agents

Describe the reaction you experienced: _____
_____

I certify that the preceding medical, personal and skin history statements are true are 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 as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____

Witness: _____ Date: _____