Alora Health Spa

Patient Information – Facial

Name: _____ Date of Birth: ____/____/_____
Occupation: _____ Phone: _____
Email: _____
How did you find us? _____

Have you been under the care of a physician, dermatologist or other medical professional within the past year? Yes/No If yes, please explain: _____
Do you take any medication? Yes/No If yes, which ones? _____
_____
Do you use Retin-A, Renova, Glycolic Acid, AHA, Salicylic Acid, Retinol/ Vitamin-A derivative products? Yes/No If yes, which ones? _____
Have you used any of these products in the last 3 months? Yes/No
Have you used an acne medication? Yes/No If yes, which one and how often? _____
_____
Do you form thick or raised scars from cuts or burns? Yes/No
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes/No If yes, which one? _____

Do you have any allergies towards scented/unscented oils, lotions or creams? Yes/No If yes, please specify_____
Please circle if you ever had an adverse reaction after using any skin care product?
Rash Irritation Peeling Sun Sensitivity Breakout
Please circle if you have ever had an allergic reaction to any of the following?
Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs
Please explain: _____

Have you had any recent surgery, including plastic surgery? Yes/No If yes, which one? _____
_____

Have you had or have cancer? Yes/No If so, what type? _____

Please circle if you suffer from any of the following:
Headaches (chronic)/Hormone imbalance/ Hepatitis/Systemic disease/Herpes/High blood pressure/Frequent cold sores/Spinal injury/Immune disorders/Thyroid condition/HIV/AIDS/ Hysterectomy/Lupus/Diabetes/Metal pins or plates/Heart problem/Phlebitis, blood clots, poor circulation/Varicose veins/Blood clotting abnormalities/Arthritis/Psychological treatment/Asthma/ Skin diseases/skin lesions/Eczema/Fever blisters/Epilepsy/Seizure disorder/Keloid scarring/ Insomnia/Any active infection:_____

Pulse rate: _____ Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High

If female, are you pregnant? Yes/No If yes, how many weeks? _____
Are you lactating? Yes/No
Any menopause challenges? Yes/No If yes, please list symptoms: _____
_____

Do you use any of the following and how often do you use them?
Cigarettes_____ Alcohol_____ Caffeine _____
Vitamins_____ Herbal Supplements _____ Aspirin_____

Do you follow a restricted diet? Yes/No If yes, please specify: _____
_____
Do you exercise? Yes/No How often? _____
What is your daily consumption of water? _____
What is your stress level? High / Medium / Low
Do you experience any problems sleeping? Yes/No
How many hours do you typically sleep each night? _____
Have you been exposed to the sun or used a tanning bed in the last 48 hours? Yes/No
How frequently are you exposed to the sun or use a tanning bed? Infrequently/Frequently
Do you have any metal implants or wear a pacemaker? Yes/No
Have you ever experienced claustrophobia? Yes/No
Do you suffer from sinus problems? Yes/No

In case of an emergency, whom should we call? Phone: _____
Relationship: _____ Name: _____

I understand 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 contraindication and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform my skin care professional of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Alora Health Spa and/or the skin care professional from liability and assume responsibility thereof.

Signature_____ Date: _____

OFFICE USE ONLY

Notes:_____
_____
_____
_____
_____
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_____