Albuquerque
Alternative Health

NEW CLIENT PAPERWORK – AAH MEDICAL SPA

All information provided is completely confidential and will not be shared.

Full Name: (Mr./Mrs./Ms./Dr.) _____
Date of Birth: ____/_____/_____ **Age:** _____ **Gender:** M F

Primary Phone Number: (_____) _____-_____ Cell/Home Phone
E-mail: _____
Street Address: _____
City, State, Zip: _____
Occupation: _____ **Employer:** _____

Most preferred method of contact: Text/ Call/ E-mail
How did you hear about us? _____

Emergency Contact: Name**:** _____
Phone: (_____) _____-_____ Relationship to you**:** _____

What are your cosmetic goals for your skin or body? _____
_____
_____
_____

Tell us about your skin: *circle all that apply*

Volume Loss	Dry	Oily	Active Acne	Large Pores
Discoloration	Wrinkles	Laxity	Broken Capillaries	Scarring

Other: _____

What does your current daily skincare routine entail? *circle all that apply*

Cleanser	Toner	Serums	Moisturizer
Acne Products	Vitamin-A Derivatives	Melanin Suppressant	SPF

Other: _____

Medical History

*** Do you have any current or chronic medical conditions?** Yes No

If yes, please specify: _____

*** Do you take any medications, herbal or natural supplements on a daily basis?** Yes No

If yes, please specify: _____

*** Do you have any allergies? (i.e., medications, foods, latex, gold, corn, or any substances)** Yes No

If yes, please specify: _____

*** Please list any medical surgeries/procedures you have had in the past 5-10 years:** _____

_____

*** Have you had any cosmetic treatments in the past? (i.e., surgeries, injectables, lasers, etc.)** Yes No

If yes, please specify: _____

*** Are you currently under the care of a dermatologist or any other physician?** Yes No

If yes, please specify: _____

*** Have you been diagnosed with any type of skin cancer, rosacea, melasma, or vitiligo?** Yes No

If yes, please specify: _____

*** Do you have any bleeding disorders?** Yes No

If yes, please specify: _____

* **Do you have a history of keloid scarring (raised scars)?** Yes No

If yes, please specify: _____

* **Do you have a history of atypical moles, melanoma, or skin cancer in yourself or family?** Yes No

If yes, please specify: _____

Medical History *continued*

* **Do you have a history of cold sores or fever blisters?** Yes No

If yes, please specify: _____

* **Do you have a history of hyper- or hypo- pigmentation?** Yes No

If yes, please specify: _____

* **Are you pregnant, planning on becoming pregnant, breastfeeding, or undergoing fertility or hormone treatments?** Yes No

If yes, please specify: _____

* **Do you have any tattoos or permanent makeup?** Yes No

If yes, please specify: _____

* **Do you have a pacemaker, internal defibrillator, electrical implant, or any medical implants in your body, face, or mouth?** Yes No

If yes, please specify: _____

* **Have you ever had a bad reaction to any skincare products?** Yes No

If yes, please specify: _____

* **Have you ever been on Accutane?** Yes No

If yes, please specify: _____

* **Are you currently using any vitamin A derivatives like Retin-A, Retinol, Tretinoin, etc.?** Yes No

If yes, please specify: _____