DFW Medical Spa
1009 Glade Road, Ste. E
Colleyville, TX
469-279-9897

Client Medical History

Do you have or have you ever had any of the following? Please check all that apply:

____ Allergies____ Anxiety Disorder____ Arthritis/Joint Problems ____ Autoimmune Disorder
____ Back Problems____ Blood Disease____ Cancer____ Chemical Dependency
____ Circulatory Problems ____ Depression____ Diabetes____ Epilepsy_____
____ Headaches____ Heart Problems____ Hemophilia/Bleeding Disorder ____
____Hepatitis/Liver Disease____ High Blood Pressure____ HIV/AIDS____ Nervous Problems
____ Pacemaker____ Psychiatric Care ____ Radiation Treatment ____ Recent Weight Loss
____ Respiratory Disease ____ Sinus Problems ____ Stroke____ Swollen Neck Glands
____ Ulcer Disease

Please list previous surgeries and aesthetic procedures, including dates:
_____
_____

Please list all medications you are currently taking (including aspirin and any NSAIDS):
_____
_____

Please list all vitamins and nutritional supplements you are currently taking:
_____
_____

Allergies:
_____

Have you ever had a reaction to any of the following? Please check all that apply:
_____ Iodine_____ Seafood_____ Collagen injections _____ Porcine (pig) products
_____ Hyaluronic acid injections_____ Any dermal fillers
_____ Any local anesthetic, including lidocaine_____ Eggs/albumin

Do you regularly sunbathe, use tanning booths, or apply tanning creams? YES NO
If yes, when was the last time you did any of the above?
_____

Have you ever had dermabrasion or a chemical peel? YES NO
If yes, what was the date of your last treatment?
_____

Are you currently using, or have you ever used Retin-A? YES NO
If yes, when did you start? _____ When did you stop?_____

Are you currently using, or have you ever used Accutane? YES NO
If yes, when did you start? _____ When did you stop_____

Do you have any skin conditions? YES NO If yes, please specify:
_____

Do you have, or have you ever had vitiligo (loss of skin pigment)? YES NO
If yes, how has it been treated? _____

Do you ever get cold sores, canker sores, or herpes eruptions? YES NO
If yes, how has the condition been treated?
_____

Do you form keloids (extra large/prominent scars)? YES NO
Do you currently smoke? YES NO If yes, how many packs per day? _____
How many years? _____

If no, but you were previously a smoker, how many years did you smoke?_____

Do you drink alcohol? YES NO If yes, approximately how many drinks per week? _____

What is the main reason for your visit today?
_____
_____
_____

Please list all areas of concern that are relevant to you:
____ Fine lines and wrinkles____ Lines around nose and mouth ____ Skin texture
____ Uneven skin tone____ Dark circles or bags under eyes ____ Acne____ Scars/acne scars
____ Brown/red/purple discolorations____ Spider veins, face or legs
____ Hands (loss of volume, veins, discoloration) ____ Sun damage
____Other_____

Are there any specific questions you would like to have answered during your initial visit?
_____
_____

_____
Patient Signature Date

LIMITATION OF TREATMENT Please understand that our practice is strictly limited to cosmetic procedures. You understand and acknowledge that we do not examine or treat you for malignancy (cancer) or non-cosmetic skin abnormalities. Skin cancer is an extremely serious (potentially fatal) condition and must be treated immediately. You should be examined on a regular basis by a dermatologist, and you should bring any concerns regarding skin changes or skin cancer to the attention of a dermatologist immediately.

BY YOUR SIGNATURE BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THE FOREGOING.

_____ _____
Patient Signature Print Name Date