Conroe Aesthetics & Wellness

Client Information & Medical History

In order to provide you with the most appropriate treatments, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFORMATION:

Patient Name: _____ **Today's Date:** _____

Date of Birth: ____/____/____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Email: _____

Emergency Contact Name and Phone Number: _____

Please circle the best method to reach you**:** **Home** **Cell Phone** **Email**

May we place you on our EBLAST list for specials, events, etc.? **Yes** or **No**

How did you hear about Conroe Aesthetics & Wellness: _____

MEDICAL INFORMATION:

Are you currently under the care of a physician? **Yes** **No** If yes, for what: _____

Are you currently under the care of a Dermatologist? **Yes** **No** If yes, for what? _____

Please circle any of the medical conditions below that apply to you:

- Cancer
- Chemotherapy/Radiation
- Diabetes
- Keloid Scarring
- Frequent Cold Sores
- Skin Disease/Skin Cancer
- Seizure Disorder
- Thyroid Imbalance
- Hormone Imbalance

- HIV /AIDS
- Hepatitis
- Acne
- High Blood Pressure
- Anemia
- Arthritis
- Blood Clotting Abnormalities
- Heart Disease
- Mental Disorder

Please list any drug allergies: _____

Please list all current medications and vitamin/ natural supplements that you are taking: _____

_____

_____

Are you pregnant or trying to get pregnant? **Yes** **No** Breast feeding? **Yes** **No**

Have you ever used Accutane? **Yes** **No** If yes, when was the last time you used it? _____

Are you currently taking:

Birth Control Pills **Hormones** **Mood Altering or Anti-Depressants** **Topical Medications or Creams**

AESTHETIC HISTORY:

Do you smoke? **Yes** **No** (How often) _____ Do you live with a smoker? **Yes** **No**

Do you drink alcohol? **Yes** **No** (How often) _____ How much water do you drink daily? _____

Do you exercise? **Yes** **No** If so, how often: _____ Do you use tanning beds? **Yes** **No**

Date of last sun exposure? _____

Please circle your skin concerns:

Sun Spots	Acne/Acne Prone Skin	Hyperpigmentation
Skin Laxity	Rosacea	Hypopigmentation (white spots)
Oiliness	Broken Capillaries	
Dry/Rough Patches	Thin/Fragile Skin	
Dehydrated	Wrinkles	

Please circle the treatments that you have had in the past:

Botox Injections	Laser Skin Rejuvenation (Photo Facials/skin Tightening)
Dermal Fillers (Juvederm)	Laser Hair Removal
Chemical Peels	Waxing
Dermal Planing	HydraFacials
Microdermabrasions	Facial Treatments

Please asterisk any of the above treatments that you may be interested in.

I acknowledge that all above information is true and correct. I am aware that it is my responsibility to inform the physician, aesthetician, technician, etc. of any new medical or health conditions.

Patient Signature _____ **Date** _____