urban effects MEDSPA

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Name:	Last Name: First Name:	Appointment Date:

How were you referred to Urban Effects Medspa? (Circle All That Apply)

Friend	Healthcare Provider:	Internet Search	Word of Mouth	Event	Gift Certificate
Facebook	TV	Vendor Website	Other	Please specify referral source: Search engine word, website, name etc.	

What is your reason for coming to Urban Effects today?

We will not sell, share or rent your email address, or any other information collected on this form. We use email as a form of appointment confirmation and communication with our patients. You may opt in/out of any/all email communication at any time you choose. (Please print legibly)

Email:	
Address:	
City/State/Zip:	

Telephone:	Cell: ( )	Work: ( )	Home: ( )
Date of Birth:	Mo/Day/Year / /	Occupation:	

Do you smoke?	Yes	No
Do you have any allergies?	Yes	No

If yes, please list:

Are you pregnant?	Yes	No
Are breast feeding?	Yes	No
Are you trying to conceive?	Yes	No

Please indicate if you had any of the following conditions by checking all that apply

Hyperpigmentation		Keloids		Heart Disease		HIV	
Acne		Warts		Hypertension		Epilepsy	
Rosacea		Herpes, cold sores		Diabetes		Pacemaker/ Defibrillator	
Inflammatory Skin Conditions		Skin Cancer		Thyroid Dysfunction		Immunological Problems	
Photosensitivity		Mole Removal		Cancer		Hepatitis	
Eczema		Skin Disease		Liver Disease		Mental Illness	
Psoriasis		Neuro-muscular Disease		Kidney Disease		Other:	

Have you ever taken Acutane for acne? If yes, when:

Please complete the reverse side

Ethnicity:

Your Ethnicity			
Fathers Heritage		Mothers Heritage	
Medical Issues:			
Current			
Past			
Medications			
Previous Surgeries			
Skin Product Regimen Used at Home:			
AM			
PM			

Previous Spa Treatments: (Check)							
Facials		Peels		Microdermabrasion		Waxing	
Previous Laser Treatments: (Check)							
Hair Removal		Vascular		Resurfacing		Scarring	
Brown Spots		Improve Texture		Skin Tightening		Acne	
Previous Dermatology Treatments: (Check)							
BOTOX®	Between Brows		Forehead		Crow's Feet		Other	
Filler	Smile Lines		Cheeks		Lips		Other	
Other							

Skin Concerns: (Check all that apply)						Other Concerns:	
Wrinkles		Tired & Dull Look		Acne		Weight Loss	
Mouth Lines		Dry Skin		Melasma		Unwanted Hair	
Brown Spots		Anti-Aging		Moles		Spider Veins	
Vascular		Oily Skin		Painful Skin			
Improve Texture		Large Pores		Itchy Skin			
Sagging Skin		Acne Scarring		Stretch Marks			

Lifestyle: (Circle)				
How many glasses of water do you drink per day? (8oz.)		0	1-4	5 or more
How many times per week do you exercise?	0	1-3	4-5	6-7
How would you assess your nutrition?	Poor	Fair	Good	Very Good
Please assess your stress level	Low	Avg.	High	Very High

Current Skin Care Products (Check what you use & list the brand)		
Cleanser		
Toner		
Moisturizer		
Exfoliator		
Sun Protection		
Topical Antioxidants		
Makeup		
Other (describe)		

Additional Comments and Concerns:

The above information is true and accurate to the best of my knowledge

_____ _____

Patient/Guest Signature Date