

# Euro Med Spa

Hair & Vein Removal ~ Sun Spot Removal ~ Juvederm ~ Botox ~ Skin Care

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Mo Day Yr

Address: \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Yr

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## Best phone number to contact you regarding your treatment and where we may leave a message:

Home Phone:( ) \_\_\_\_\_ Cell Phone:( ) \_\_\_\_\_ Work Phone:( ) \_\_\_\_\_

E-mail \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ PCP Phone Number \_\_\_\_\_

Emergency Contact and Phone number \_\_\_\_\_

## This information is necessary for your procedure. Please answer yes or no to the following questions:

YES NO

Are you using any prescribed medications? List \_\_\_\_\_

Are you using any Herbal medications? List \_\_\_\_\_

Do you take oral anti-coagulant (blood thinning) medication? List \_\_\_\_\_

Are you allergic to any cosmetic ingredients, medications or foods? List \_\_\_\_\_

Are you pregnant or trying to become pregnant?

Do you use oral contraceptives?

Do you use hormone replacement therapy?

Do you smoke? How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you spend a lot of time outdoors or use a tanning bed often?

Do you have any tattoos or permanent makeup?

Please tell us your main concerns that brought you to our office today: \_\_\_\_\_

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Sun Damage       | <input type="checkbox"/> Brown spots (Hyperpigmentation) | <input type="checkbox"/> White spots (Hypopigmentation) |
| <input type="checkbox"/> Uneven skin tone | <input type="checkbox"/> Visible exposed blood vessels   | <input type="checkbox"/> Hard bumps under skin          |
| <input type="checkbox"/> Enlarged pores   | <input type="checkbox"/> Clogged pores                   | <input type="checkbox"/> Blackheads /Whiteheads         |
| <input type="checkbox"/> Acne             | <input type="checkbox"/> Excessive oiliness              | <input type="checkbox"/> Pimples                        |
| <input type="checkbox"/> Upper lip lines  | <input type="checkbox"/> Wrinkles                        | <input type="checkbox"/> Scarring                       |
| <input type="checkbox"/> Sun Spots        | <input type="checkbox"/> Dry patches                     | <input type="checkbox"/> Unwanted Hair                  |
| <input type="checkbox"/> Other: _____     |  |   |

What is your skin type:  Dry  Combination  Oily  Normal

How much water do you consume per day? \_\_\_\_\_

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cleanser _____    | <input type="checkbox"/> Soap _____        | <input type="checkbox"/> Toner _____                |
| <input type="checkbox"/> Moisturizer _____ | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Mask _____                 |
| <input type="checkbox"/> Eye cream _____   | <input type="checkbox"/> Astringent _____  | <input type="checkbox"/> Glycolic Wash/Cleanser     |
| <input type="checkbox"/> Scrub _____       | <input type="checkbox"/> Sunscreen _____   | <input type="checkbox"/> Salicylic Wash/Cleanser    |
| <input type="checkbox"/> Vitamin A Cream   | <input type="checkbox"/> Vitamin C Creams  | <input type="checkbox"/> Alpha or Betahydroxy Cream |

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?

Please list \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any of the following wrinkle fillers or implants:

- |                                   |                                    |                                  |                                   |                                   |                                   |                                       |
|-----------------------------------|------------------------------------|----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Collagen | <input type="checkbox"/> Restylane | <input type="checkbox"/> Perlane | <input type="checkbox"/> Hylaform | <input type="checkbox"/> Juvaderm | <input type="checkbox"/> Silicone | <input type="checkbox"/> Radiance     |
| <input type="checkbox"/> Sculptra |                                    |                                  |                                   |                                   |                                   | <input type="checkbox"/> Other: _____ |

\* If so then when was it done? \_\_\_\_\_ What area? \_\_\_\_\_ By whom? \_\_\_\_\_

Please check any health problems, past or present:

- |  |   |  |                                      |                                    |
|--|---|--|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Skin cancer (Type: _____)       |                                      |                                    |
| <input type="checkbox"/> Hormonal Problems   | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Cystic Acne                     | <input type="checkbox"/> Thyroid     | <input type="checkbox"/> Cancer    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Collagen (Lupus,                | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Vasovagal Syncope   | <input type="checkbox"/> PCOS           | <input type="checkbox"/> Autoimmune (lupus, scleroderma) |                                      | <input type="checkbox"/> Asthma    |
| <input type="checkbox"/> Other: _____        |   |  |                                      |                                    |

Do you have any of the following chronic skin disorders?

- |   |                                     |                                       |  |
|---|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Psoriasis      | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Keloid Scarring         |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sun Blisters | <input type="checkbox"/> Herpes Simplex/Blisters |

Have you ever undergone any of the following treatments?

- |  |                                    |   |                                 |                                |                                   |
|--|------------------------------------|---|---------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Macrodermabrasion | <input type="checkbox"/> Acid Peel | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Lasers | <input type="checkbox"/> Botox | <input type="checkbox"/> Accutane |
| <input type="checkbox"/> Microdermabrasion |                                    |   |                                 |                                |                                   |

When and where was it done? \_\_\_\_\_

Are you currently removing hair by any of the following methods?

- |                                 |                                   |   |                                       |   |
|---------------------------------|-----------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Tweezing | <input type="checkbox"/> Hair+type products | <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Laser Hair Removal |
|---------------------------------|-----------------------------------|---|---------------------------------------|---|

\* If so when was it done \_\_\_\_\_ what area \_\_\_\_\_ and what type of laser? \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Patient's Signature

**Euro Med Spa Solutions Notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr Iqbal will be assisted by \_\_\_\_\_

