SPA·VIE

PATIENT STICKER

HISTORY INTAKE FORM

Patient Name: _____ **Birth Date:** _____
Address: _____ **Phone #:** _____
City: _____ **State:** _____ **Zip:** _____ **Email:** _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE.

Reason for your visit: _____
_____

How did you hear about us?

- ❑ From a friend
- ❑ Television
- ❑ Twitter
- ❑ Facebook
- ❑ Instagram
- ❑ Real Self
- ❑ LinkedIn
- ❑ Other_____

Smoking (type & frequency): _____ **Alcohol (drinks per week):** _____
If former smoker, quit date: _____ **Weight:** _____ **Height:** _____
Exercise (type & frequency): _____ **Weight Stable?** _____

Sun Exposure:

- ❑ Mild
- ❑ Moderate
- ❑ Severe

Occupation: _____
Drug allergies: _____
List any ongoing chronic illnesses: _____
List previous surgeries: _____
Current medications: _____
_____

MEDICAL HISTORY

Do you have a bleeding problem?	**Yes… No…**	**Wear contacts?**	**Yes… No…**
Ever experienced a blood clot?	**Yes… No…**	**Mole concerns?**	**Yes… No…**
Do you have diabetes?	**Yes… No…**	**History of cold sores?**	**Yes… No…**
Are you pregnant or nursing?	**Yes… No…**	**Skin rejuvenation procedure in last 6 wks?**	**Yes… No…**

Interested in information regarding our wellness program for Hormone Balancing and HCG Weight Loss? **Yes… No…**

Interested in information regarding Botox/Dysport, Dermal Fillers, CoolSculpting, Profound RF, Geneveve, Sciton Laser, Miradry, Alastin Skincare, or Cellfina?

I VERIFY THAT THE ABOVE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient Signature: _____ DATE: _____