EGÉA The North Shore's Wellness Spa

Consultation and Health History

Name: ____ Date: ____________________

Email address:_____________________________________ Birth Date:_____/_____/________

Address: ________________________________ City:________________ State:_____ Zip:_____

Cell Phone:___________________________ Home Phone:__________________________

MEDICAL HISTORY

Are you experiencing any health problems? YES NO

If yes, what? ____

____

What oral medications are you currently using? (In the past 2-3 months)

Antibiotics Hormones Birth Control Diuretics Thyroid Blood Thinner

Other: ____

Are you allergic to Latex? YES NO

Are you Diabetic? YES NO

Circle your level of stress (1 low, 10 high) 1 2 3 4 5 6 7 8 9 10

At any time in the present or the past have you gotten cold sore or herpes? YES NO

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? **YES NO**

SKIN HISTORY

Have you ever seen a dermatologist? YES NO

If yes, when/why? ____

Have you ever had a skin allergy? YES NO

Do you have any known drug or food allergies? YES NO

If yes, to what drug or food? ____

Do you experience any claustrophobia? YES NO

What type of massage do you prefer? Light Firm

What level do you consider your pain threshold to be? Low High

What temperature of water do you use to cleanse? Cool Warm Hot

What skin care products are you using currently? ___________________________

Are you using an eye cream? YES NO

Are you using a sunscreen every day? YES NO

Have you had any enzyme or chemical peels? YES NO

Have you ever had a microdermabrasion treatment? YES NO
Have you used Accutane? YES NO

What topical medications do you use or have you used?________________________

Retin-A Glycolic Acid Lactic Acid Salicylic Acid Other: ________________________

Have you ever had laser procedure? YES NO

If yes, in what area? ________________________

How long ago? ________________________

Have you ever had **facial plastic surgery**? YES NO

If yes, in what area? ________________________

How long ago? ________________________

Have you ever had any Injectables? Botox Radiesse Juvederm None

VASCULARITY

Broken Capillaries: Nose Cheeks Chin Forehead Entire Face

Do you blush easily? YES NO

Have you been told you have Rosacea? YES NO

SUN HISTORY

Have you been in the sun lately? YES NO

If yes, when? ________________________

Are you going on vacation any time soon? YES NO

If yes, when? ________________________

How much time do you spend in the sun in the summer: ½ hr/day 1hr/day 2+hrs/day

In the past have you lived in a sunbelt state and sunbathed? YES NO

In the past have you neglected to use sun block? YES NO

Do you go to a tanning salon? YES NO

Are you using a self tanner? YES NO

Do you have: Birthmarks Freckles Redness Pregnancy Mask

FREE RADICAL EXPOSURE

Do you smoke? YES NO

Do you consume alcohol? YES NO

Do you have a healthy diet? YES NO

Do you exercise? YES NO

Do you take vitamins/supplements? YES NO

How much water do you consume daily? ____________oz.

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SKIN TYPE

Does your skin ever flake or feel tight and dry?	Frequently	Occasionally	Rarely
Is your skin ever shiny a few hours after cleansing?	Frequently	Occasionally	Rarely
How often do you experience blackheads or blemishes?	Frequently	Occasionally	Rarely
What type of blemish do you get?	White heads	Black heads	
What skin type do you consider yourself to have?	Oily Acneic	Dry	Normal
Mature Combination?		YES	NO
Does your skin appear sensitive?		YES	NO
Do you form thick or raised scars?		YES	NO
Do you use wax or other depilatories?		YES	NO

WOMEN ONLY

Do you have regular periods?	YES	NO
Are you going through menopause?	YES	NO
During pregnancy, did you get hyperpigmentation or masking?	YES	NO
Are taking oral contraception?	YES	NO
Are you trying to become pregnant?	YES	NO
Are you pregnant or lactating?	YES	NO
Are you currently having or due for your menstrual period?	YES	NO

MEDICATIONS THAT ARE CONTRAINDICATED FOR LASER AND PEELS:

[ ] **Antibiotics**: quinolones [ie: ciprofloxacin (Cipro), Proquin, levoflaxacin (Levaquin)], tetraycyclines [ie: Acrhomycin, doxycycline (Vibramycin, Oracea, Adoxa, Atridox & others], sulfonamides [ie: sulfamethoxazole & trimethoprim; cotrimoxazole (Bactrim, Septra), sulfamethoxazole, (Gantanol)]

[ ] **Antihistamines**: diphenhydramine (Benadryl)

[ ] **Malaria medications**: quinine (Quinerva, Quinite, QM-260); chloroquine (Alaren), hydroxychloroquine (Plaquenil)

[ ] **Cancer chemotherapy drugs**: 5-fluorouracil (5-FU, Efudex, Carac, Fluoroplex); vinblastine (Velban, Velsar); dacarbazine (DTIC-DOME)

[ ] **Cardiac drugs**: amiodarone (Cordarone); nifedipine (Procardia); quinidine (Quinaglute, Quinidex); diltiazem (Cardizem, Dilacor, Tiazac)

[ ] **Diuretics**: furosemide (Lasix); thiazides [hydrochlorotiazide (Hydrodiuril)]

[ ] **Diabetic drugs**: sulfonylureas [chlorpropamide (Diabinese), glyburide (Micronase, DiaBeta, Glynase)]

[ ] **Painkillers**: nonsteroidal anti-inflammatory drugs [naproxen (Naprosyn, Naprelan, Anaprox, Aleve); piroxicam (Feldene)]

[ ] **Skin medications**: photodynamic therapy for skin cancer [ALA or 5-aminnolevulinic acid (Levulan), Methyl-5-aminolevulinc acid]

[ ] **Acne medications**: isotretinoin (Accutane); acitretin (Soriatane)

[ ] **Psychiatric drugs**: phenothiazines [chlorpromazine (Thorazine)], tricyclic antidepressants (Norpramin), imipramine (Tofranil)

PLEASE INDICATE IF YOU HAVE/USE ANY OF THE FOLLOWING

		CONTRAINDICATED FOR:
	Accutane	AFT, Pixel
	Acute inflammation	NIR
	Anemia	Pixel
	Anticoagulation treatment	NIR, AFT
	Bleeding disorders	Pixel
	Cancer, in particular skin cancer	NIR, AFT, Pixel
	Cellulitis (MRSA)	Pixel
	Chronic disease (Crohn's, IBD, etc)	Pixel
	Cold sores (past or present)	NIR, AFT, Pixel
	Collagen Vascular disease	Pixel
	Diabetes	AFT
	Epilepsy	NIR, AFT
	Fragile and dry skin	NIR, AFT
	Hemorrage	NIR, AFT
	History of coagulopathies/ thrombophlebitis	NIR
	History of keloid scarring	NIR, AFT, Pixel
	Hormonal disorders stimulated by intense light	NIR
	Immunosuppresion	Pixel
	Lichen Nitidus	Pixel
	Lichen Planus	Pixel
	Malignancy	Pixel
	Multiple Sclerosis	Pixel
	Open wounds, skin injuries or recent inflammation or burns	NIR, AFT
	Peripheral Vascular Disease	Pixel
	Poorly controlled Diabetes Millitus	Pixel
	Pregnancy, including IVF treatments	NIR, AFT, Pixel
	Prolonged sun exposure or artificial tanning 3-4 wks before	NIR, AFT
	Psoriasis	Pixel
	Renal failure (acute or chronic)	Pixel
	Thryobocytopenia	Pixel
	Use of photosensitive medication and/or herbs	NIR, AFT
	Vitiligo	Pixel

PATIENT OBJECTIVE

What areas do you want to treat and why? (Please check all that apply and be specific.)

[ ] Face ______________________________

[ ] Eyes______________________________ [ ] Cheeks______________________________

[ ] Mouth______________________________ [ ] Neck______________________________

[ ] Chest______________________________ [ ] Back______________________________

[ ] Hands______________________________ [ ] Forearms______________________________

[ ] Other______________________________

What services would you like to learn more about? (Please check all that apply)

[ ] Laser 360 Program [ ] Skin Tightening [ ] Acne Treatment

[ ] Individual laser treatments [ ] Injectables [ ] Facials

[ ] Advanced exfoliation [ ] Anti-aging [ ] Laser hair removal

[ ] Medical grade home care products