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

At any time in the present or the past have you gotten cold sore or herpes? 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? _____

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

What skin care products are you using currently? _____

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

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

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

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

Do you blush easily? YES NO

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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?

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

Are you trying to become pregnant?	YES	NO
Are you pregnant or lactating?	YES	NO

PATIENT OBJECTIVE

When was your last facial: _____

What skin care products are you currently using:

Cleanser: _____

Moisturizer: _____

Eye Cream: _____

SPF: _____

Other: _____

_____

Makeup: _____

_____

What areas are you concerned about and why? (Please check all that apply and be specific.)

[ ] Acne
[ ] Hyperpigmentation
[ ] Redness
[ ] Fine Lines & Wrinkles
[ ] Oily Skin
[ ] Dry Skin

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

[ ] Laser 360 Program
[ ] Individual laser treatments
[ ] Advanced exfoliation
[ ] Medical grade home care products
[ ] Skin Tightening
[ ] Injectables
[ ] Anti-aging
[ ] Acne Treatment
[ ] Facials
[ ] Laser hair removal
[ ] Latisse