

MAROD MEDICAL SPA

CLIENT INFORMATION

First Name _____ Last Name _____ Age _____

Address _____ City _____ State _____ Zip _____

Birthday _____ Anniversary _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

Cell Phone _____ Spouse _____

Email _____

May we contact you by e-mail? Yes__ No__

Preferred phone contact: Home__ Work__ Cell__

Referred By _____

Staff Preference _____ Alternate Staff _____

Credit or Debit # _____ Ex _____

(A credit card number is required to hold an appointment. There will be a \$25.00 charge applied to this card if you do not give 24-hour notice of cancellations and/or rescheduling.)

Patient Signature _____ Date _____

Office Use Photo _____ Date _____ Initials _____

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Consultation Questionnaire

Name _____ DOB _____

Please list all medications you are currently taking, including over the counter herbal remedies.

Please list any allergies to medications or other substances. _____

Are you currently under a physicians care for any illness? _____

Please answer yes or no to the following questions.

Have you ever had a heart condition?	YES__	NO__
Do you have a seizure disorder?	YES__	NO__
Do you bruise easily?	YES__	NO__
Does your skin pigment easy?	YES__	NO__
Any hypertrophic or keloid scars?	YES__	NO__
Have you ever used Retin A or AHA?	YES__	NO__
Have you ever taken Accutane?	YES__	NO__
Do you have any tattoos?	YES__	NO__
Do you use a tanning bed?	YES__	NO__
Do you use any tobacco or alcohol?	YES__	NO__
Have you had any other cosmetic procedures, microdermabrasion, chemical peels, or plastic surgery?	YES__	NO__
Are you pregnant or planning to become pregnant?	YES__	NO__
Do you have any blood disease, e.g., Hepatitis, HIV, or AIDS?	YES__	NO__
Do you have diabetes?	YES__	NO__
Do you have any healing problems?	YES__	NO__
Do you get cold sores?	YES__	NO__

Patient Signature _____ Date _____