Aislinn Medical Spa

Patient Information Intake Form

On behalf of our providers and staff, we would like to take this opportunity to welcome you to Aislinn Medical Spa. Thank you for your kind cooperation in filing out our information sheet.

Today's Date: _____

Patient Information:

Full Name: _____DOB: _____

Address: _____City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Marital Status: (please circle) S M W D Occupation: _____

Email Address: _____ May we leave you a voicemail? Yes No

Missed/Canceled Appointments: We would appreciate the courtesy of a call if you are unable to keep an appointment. Please notify our office at least 24 hours in advance if you need to cancel or reschedule. We reserve the right to charge you a $25 fee when not given a 24 hour advance notice.

Emergency Contact: (Name) _____Relationship: _____

Phone Number: _____ Primary Care Physician: _____

Referral Information: How did you hear about us? (Circle one)

Internet Search Google Yelp Facebook Instagram Women's Edition Mailer/Flyer Gretna Chamber

Friend: (Name) _____ Other: _____

Patient History

Please list any medications, including prescription or over-the-counter medicines/vitamins you are taking:

1. _____ Reason for taking: _____
2. _____ Reason for taking: _____
3. _____ Reason for taking: _____
4. _____ Reason for taking: _____
5. _____ Reason for taking: _____
6. _____ Reason for taking: _____
7. _____ Reason for taking: _____
8. _____ Reason for taking: _____

Please list any medication and/or environmental allergies you have and what reaction you will have with each allergy:

_____

_____

Are you allergic to Latex?	Y	N	Are you allergic to tape?	Y	N
Do you smoke cigarettes?	Y	N	Are you pregnant?	Y	N
Do you chew tobacco?	Y	N	Are you planning on pregnancy?	Y	N
Do you drink alcohol?	Y	N	Are you breastfeeding?	Y	N
Do you use recreational drugs?	Y	N	Do you drink caffeine?	Y	N

Do you go tanning in a tanning bed or booth? Y N If yes, how often? _____

When was the last time you tanned or were out in the sun for tanning purposes? _____

Have you ever had any of the following?

Retin A	Y	N	Liposuction	Y	N
Botox	Y	N	Lipodissolve	Y	N
Filler	Y	N	Coolsculpting	Y	N
Laser Hair Removal	Y	N	Hormone Therapy	Y	N
Sclerotherapy (leg veins)	Y	N	Chemical Peel	Y	N
IPL (or BBL)	Y	N	Laser Peel	Y	N
Hyperpigmentation (darkening skin)	Y	N	Microdermabrasion	Y	N
Hypopigementation (lightening skin)	Y	N	Skin Disease	Y	N

Skin:

Have you ever been treated for acne?	Y	N
Have you ever had skin cancer?	Y	N
Do you have problems healing?	Y	N
Are you prone to cold sores?	Y	N
Do you have eczema or psoriasis?	Y	N
Do you have genital herpes?	Y	N
Do you have rosacea?	Y	N
Do you develop keloid scars?	Y	N
Do you have sensitive or allergic skin?	Y	N

Do you have now, or have you ever had diseases or conditions of?

Artificial Joint	Y	N	Hepatitis	Y	N
Autoimmune Disease	Y	N	High Blood Pressure	Y	N
Blood Clots	Y	N	HIV or AIDS	Y	N
Phlebitis (Inflammation of skin)	Y	N	Irregular Heart Beat	Y	N
Convulsions or Epilepsy or Seizures	Y	N	Lung Disease or Asthma	Y	N
Diabetes	Y	N	Pacemaker	Y	N
Depression/Anxiety	Y	N	Cancer	Y	N
Heart Attack	Y	N	Thyroid	Y	N

Past Surgical History:

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Pregnancy #: _____ Delivery #: _____

Family History:	**Family Member Affected:**
Heart Disease	_____
Hypertension	_____
Stroke	_____
Cancer	_____
Diabetes	_____
Other	_____

Nutritional/Natural Supplements

Please identify and list the products you are currently using:

Vitamins (single or multiple): _____

Minerals (Calcium, Magnesium, etc): _____

Nutrition/Protein Supplements (protein powders, amino acids, etc): _____

Others: _____

Patient Signature: _____