

Name: _____ Birth Date: ____ / ____ / ____

Address: _____

City: _____ State: ____ Zip Code: _____

Home: (____) _____ Work: (____) _____ Cell:(____) _____

Email: _____

Emergency Contact: _____ Phone: (____) _____

Allergies: _____

For women: Are you currently pregnant? _____

How did you hear about TRIMEDICA SPA? _____

Please put a check mark next to the procedures about which you would like to receive more information:

- Enhanced Skin rejuvenation
- Facials
- Chemical Peels
- Microdermabrasion
- Skin Care Program
- Acne treatments
- Broken Capillaries/ Rosacea
- Sun Damage/Brown Spots
- Non Surgical Laser Body Contouring
- Laser Hair removal
- Shaving Bumps/Ingrown Hair
- Botox® To Flatten and Prevent Wrinkles
- Juvederm (Facial Filler)
- Other _____

Please put a check mark next to a past or current medical condition:
Medical History:

- Lupus or other auto-immune deficiency
- Rheumatoid Arthritis "Gold" Therapy
- Currently Pregnant
- Bleeding abnormalities
- Treatment with Accutane® in the last year
- Treatment with Tetracycline® in the last month
- Keloid or very thick scarring
- Psoriasis or Vitiligo
- Pulmonary embolism/blood clot
- Leg ulcer or Phlebitis
- Blood thinning medication
- Coumadin®/anti-clotting agents
- Cystic Acne
- Herpes simplex or fever blisters
- Diabetes
- Light sensitive Epilepsy
- Scars that turn white or brown
- Dark spots after pregnancy, skin injury
- HIV
- Hepatitis
- Waxing/Plucking/Electrolysis within last four weeks
- Hirsutism
- Transplant Anti-Rejection Drugs
- Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift
- Tattoos/permanent make-up
- Polycystic ovarian disease (PCOD)
- Implants (Location:_____)
- Collagen injection (Location:_____)

Please list any medications or herbal supplements that you are currently taking:

Patient

Signature: _____ Date: _____

Age: _____ Sex: M / F _____