Renaissance Medical Spa

Date _____ Home Phone_____ Cell Phone_____

Last Name: _____First Name: _____Nick Name:_____

Address _____City, State, Zip_____

Sex: ❑ Male ❑ F emale Birthdate: ____/____/____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Anniversary: ____/____/___ SS# (last 4 digits) _____ Referred by: _____

Employer: _____ Work Phone: _____

Preferred Language: _____ Race & Ethnic Group: _____

Occupation:_____ If student: ❑ Full-time ❑ Part-time Email: _____
(We email monthly specials, birthday discounts, etc.)

In case of emergency who should be notified?_____ Phone:_____

Do we have permission to:
- Leave a message on your answering machine: ❑ Yes ❑ No
- Leave a message at your place of employment? ❑ Yes ❑ No
- Discuss your medical condition with any member of your household? ❑ Yes ❑ No

May we discuss information regarding your services with any memeber of your household? ❑ Yes ❑ No

If yes, whom:_____ Relationship:_____

Are you using any of the following products?

❑ Renova ❑ Glycolic Acid ❑ Benzoyl Peroxide ❑ Accutane ❑ Retin-A

Do you wear contact lenses? ❑ Yes ❑ No
Do you wear dentures? ❑ Yes ❑ No
Do you exercise regularly? ❑ Yes ❑ No
How much water do you drink per day? _____ glasses
Have you ever received a massage before? ❑ Yes ❑ No
Have you ever received a facial before? ❑ Yes ❑ No
Have you ever received a manicure/pedicure before? ❑ Yes ❑ No

Please take a moment to carefully read the information you have provided to be sure it is as accurate as possible. If you have a specific medical condition or specific symptoms, certain treatments may be contraindicated. Please discuss any questions with your service provider prior to service.

_____ _____ Circle One: Self Parent Guardian
Signature of Patient or Legal Guardian Date

_____
Print Name

GUARDIAN OR ADULT SIGNATURE IS REQUIRED IF PATIENT IS UNDER 18

Name:_____ DOB_____ Date:_____

Circle All That Apply

Bleeding Problems Yes No

Healing Problems Yes No

Scarring Yes No

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Do you have allergy to adhesive? Yes No

Do you have a reaction to lidocaine (local anesthetic injection)? Yes No

Do you experience rapid heartbeat with epinephrine (in local anesthetic injections)? Yes No

Are you allergic to any topical antibiotic ointments? Yes No If so, what:_____

Have you ever had MRSA (staph infection)? Yes No

Have you ever had difficulty stopping bleeding? Yes No

Are you on any blood thinners? Yes No

Do you have a defibrillator? Yes No

Do you have a pacemaker? Yes No

Do you have an artificial heart valve? Yes No

Have you had an artificial joint replacement within the past two years? Yes No

If yes, when and what body locations:_____

Do you require antibiotics prior to a surgical procedure? Yes No

Are you pregnant or currently trying to get pregnant? Yes No

Are you breastfeeding? Yes No

Have you traveled to West Africa or had contact with anyone who has? Yes No

Immunization History

Flu Vaccine: Yes No If yes, what year?_____

Pneumonia Vaccine: Yes No If yes, what year? _____

Zostavax (Shingles)? Yes No If yes, what year? _____

PATIENT SIGNATURE:_____ **DATE**_____

Name:_____ DOB_____ Date:_____

Smoking Status: **Circle All That Apply**

Every Day Smoker

Occasional Smoker

Former Smoker

No History of Smoking

If yes, heavy or light?_____

Cigarettes Cigar Other Tobacco

Sexually Active: **Circle All That Apply**

Not sexually active

Sexually active with one partner

Sexually active with more than one partner

Same gender partner

Alcohol Use: **Circle All That Apply**

No History of Alcohol Use

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

In the past year, have you had 2 or more days, that you have had greater than 4 drinks in one day?

Yes No

ILLEGAL Drug Use: **Circle All That Apply**

Current Drug Use Yes No

History of IV Use Yes No

IV use within the past 12 months

Driving Status: **Circle All That Apply**

Drive at night

Drive during the day

Exercise: **Circle All That Apply**

Never

Once a day

Several times per day

Few times per week

Few times per month

Name:_____ DOB_____ Date:_____

History of Skin Disease **Circle All That Apply**

NO SKIN DISEASE HISTORY	Autoimmune Disease	Hay Fever/Allergies	Precancerous Moles
Acne	Basal Cell Skin Cancer	Melanoma	Squamous Cell Skin Cancer
Actinic Keratoses	Blistering Sunburn	Psoriasis	
Asthma	Eczema	Poison Ivy	

Please Circle Response

Do you wear sunscreen?	Yes	No	If yes, what SPF? _____
Do you have a history of tanning bed use?	Yes	No	
Do you have a family history of Melanoma?	Yes	No	If yes, list relative:_____

Medication List: **Please provide all medication including dosages & prescribed frequency. Also please include over the counter medications, vitamins, supplements. Please ask for additional paper if needed from receptionist.**

NONE or list below

MEDICATION	DOSAGE AND FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medication:

NONE or list below

MEDICATION	REACTION
_____	_____
_____	_____

Laurie H. Harrington, MD **Advanced Dermatology** Kristen Hebert, PA

Patient Name:_____ **DOB:** _____

Preferred Pharmacy:_____ **Pharmacy City:**_____

Referral Physician:_____ **Pharmacy Zip Code:**_____

Primary Care Physician:_____

Past Medical History: Circle All That Apply

NO PAST MEDICAL HISTORY		HIV/AIDS	Stroke
Anemia	Depression	Irregular Heart Rhythm	Stomach Ulcers
Anxiety	Diabetes	Kidney Disease	Thyroid Disease (Hyper)
Arthritis	GERD (acid reflux)	Leukemia	Thyroid Disease (Hypo)
Asthma	Hearing Loss	Lung Cancer	Tuberculosis
Breast Cancer	Heart Disease	Lymphoma	
BPH(prostate enlargement)		Organ Transplant	
Chemotherapy	Hepatitis	Prostate Cancer	
Colon Cancer	High Blood Pressure	Radiation Treatment	
Coronary Artery Disease	High Cholesterol	Seizures	

Past Surgical History

NONE or list below

_____

_____