

Capri Medical Spa

Patient History

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City, State, Zip: _____

Telephone Number that you would like to be reached at: _____

Services I am interested in learning more about:

<input type="checkbox"/> Botox Injections	<input type="checkbox"/> Injectable Fillers Cosmoderm/Cosmoplast	<input type="checkbox"/> Restylane	<input type="checkbox"/> Radiance longer -lasting filler	<input type="checkbox"/> Permanent Hair Reduction
<input type="checkbox"/> Intense Pulsed Light Photo Facial Rejuvenation	<input type="checkbox"/> Sclerotherapy (Vein Therapy) <input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Mineral Make-up <input type="checkbox"/> Facials	<input type="checkbox"/> Medical skin care products	<input type="checkbox"/> Microdermabrasion <input type="checkbox"/> Other: _____

Please check areas of concern:

<input type="checkbox"/> Acne	<input type="checkbox"/> Freckles	<input type="checkbox"/> Blackheads	<input type="checkbox"/> Eczema	<input type="checkbox"/> Dry skin
<input type="checkbox"/> Scars	<input type="checkbox"/> Spider veins	<input type="checkbox"/> Whiteheads	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Sun damage
<input type="checkbox"/> Deep wrinkles	<input type="checkbox"/> Broken Capillaries	<input type="checkbox"/> Age spots on hands	<input type="checkbox"/> Hypo pigmentation	<input type="checkbox"/> Hyper pigmentation
<input type="checkbox"/> Fine lines	<input type="checkbox"/> Moles	<input type="checkbox"/> Oily skin	<input type="checkbox"/> Melasma	<input type="checkbox"/> Shaving bumps
<input type="checkbox"/> Sensitive skin	<input type="checkbox"/> Unwanted hair	<input type="checkbox"/> Skin that itches	<input type="checkbox"/> Redness on face	<input type="checkbox"/> Other

Please check the box to the left that applies to your skin:

Check box	Skin type	Working classification	Color	Ethnicity/complexion
<input type="checkbox"/>	I	Always burns easily; never tans; extremely sensitive to sun	White	Primarily red/blonde individuals w/ light complexion
<input type="checkbox"/>	II	Always burns easily; tans minimally, very sensitive to the sun	White	The largest % of Caucasian individuals are II or III
<input type="checkbox"/>	III	Sometimes burns easily; tans gradually to light brown, sun sensitive skin	White/ Asian	The largest % of Caucasian individuals are II or III
<input type="checkbox"/>	IV	Burns minimally; always tans to moderate brown; minimally sun sensitive	Moderate brown	Oriental, American Indian, Italian, Greek, Latin descent
<input type="checkbox"/>	V	Very rarely burns; tans well, sun insensitive skin	Dark brown	Light complexion African-American or Indian descent
<input type="checkbox"/>	VI	Never burns; deep pigment; sun insensitive	Black	Dark skinned

Check Eye color:

<input type="checkbox"/> Blue	<input type="checkbox"/> Gray	<input type="checkbox"/> Green	<input type="checkbox"/> Hazel	<input type="checkbox"/> Brown	<input type="checkbox"/> Black
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Check Natural hair color now (without dyes or rinses):

<input type="checkbox"/> Blonde	<input type="checkbox"/> Red	<input type="checkbox"/> Light brown	<input type="checkbox"/> Medium brown/ Chestnut	<input type="checkbox"/> Dark brown	<input type="checkbox"/> Black	<input type="checkbox"/> Salt and pepper	<input type="checkbox"/> Gray
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Check Products you now use:

○ Cleanser	○ Sunscreen	○ Foundation	○ Powder	○ Eye makeup	○ Hair spray
○ Moisturizer	○ Eye Creams	○ Blush	○ Blush	○ Concealer	○ Hair Gels

Check Prior treatments you have had:

○ Botox	○ Injectable fillers	○ Facials	○ Sclerotherapy Vein Therapy	○ Laser resurfacing	○ Customized Skin Rejuvenation Programs
○ Hair removal	○ Medical Skin Products	○ Chemical Peels	○ Intense Pulsed Light	○ Make-up services	○ Microdermabrasion

Do any of the following conditions or treatments apply to you? If not check here

- Accutane in the last 6-12 months
- Allergies to medications, foods, latex, topical products or other substances
- Alpha Hydroxy acid products in the last 48 hours
- Autoimmune diseases (lupus, scleroderma)
- Blood thinners (Coumadin, Heparin, aspirin, ibuprofen)
- Botox in the last 2 weeks
- Cancer treatment
- Collagen injection in the last 2 weeks
- Eczema
- Herbal remedies such as St. John's Wort or Ginko Biloba
- Infections
- Immunosuppression
- Moles, warts or skin tags
- Open lesions
- Permanent make-up/tattoos
- Photosensitizing medications
- Polycystic ovaries or menstrual dysfunction
- Pregnancy/Nursing
- Psoriasis
- Plucking, waxing, tweezing, electrolysis in last 6 weeks in area for hair reduction
- Rashes
- Retin A, Renova, salicylic acid, alpha/ beta hydroxyl/ glycolic products within 2 weeks
- Seborrhea
- Seizure history
- Steroid use such as prednisone, cortisone
- Unprotected sun exposure in last 4 weeks
- Viral lesions (Herpes I, Herpes II, Shingles, cold sores)

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Do any of the following health conditions apply to you? If none apply check here

<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> HIV/Aids

List medications, Vitamins/supplements, or topical medications you have used in the past 6 months (include hormones and over the counter):

List any allergic reactions or sensitivities you have had to skin products, foods, medications, etc.

List all surgeries, including cosmetic:

Life Style Questions:

Type of Work: _____
Your stress level: ___High ___Medium ___Low
Do you smoke? ___No ___Yes How much? _____
Daily Sun Exposure: ____/hrs/day Sunscreen used? _____ SPF: _____
Water intake: ____/glasses/day
Tea/Coffee: ____/glasses/day
Alcohol: ____/amount per week
Hours of sleep? ____/per night/day
Exercise: ____/hours per week
Street drug use? ___No ___Yes How often? _____
Is your weight stable: ___No ___Yes Recent Gain /loss ____/lbs
Are you happy with your weight? ___No ___Yes

Thank you for taking the time to complete our history form. With the following information we will be better able to serve you. Our goal is to provide you with excellent service and results. At future visits, please let us know if any of the following information changes. All information and treatments are kept confidential.
