Jon'Ric INTERNATIONAL
MEDICAL SPA AND WELLNESS CENTER

Cosmetic Consultation and Medical Questionnaire

ALL SECTIONS MUST BE COMPLETED. PLEASE PRINT CLEARLY.

Today's Date: _____

Name: _____ Date of Birth: ____ /____ /____

Age: _____ Sex: _____ Height: _____ Weight: _____

Home Phone: ( )_____ Cell Phone: ( ) _____ Business Phone: ( )_____

Home Address: _____ E-mail Address: _____

City: _____ State: _____ Zip: _____

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

Spouse's Name: _____

How did you hear about us?

- ○ Friend/Family _____
- ○ Search Engine (Google, Yahoo, MSN)
- ○ Social Media (Facebook, Twitter)
- ○ Organization _____
- ○ Gift Certificate
- ○ Walk In
- ○ Product Website: _____
- ○ Other: _____

List all cosmetic procedures you have had (Botox, Lasers, Injectable Fillers, Peels)

Procedure	Year	Doctor/Spa	City

[ ] Yes [ ] No Were there complications? (If yes, please explain) _____

[ ] Yes [ ] No Did you have a normal recovery? (If no, please explain) _____

[ ] Yes [ ] No Were you satisfied with the results? (If no, please explain) _____

List Medical Conditions (Hypertension, Diabetes, Cancer, etc.)

_____

_____

List Surgeries, including cosmetic (breast augmentation, face lift, eyelid surgery, etc.)

_____

_____

Are you currently under the care of a physician for a medical/surgical/psychiatric problem?

Explain: _____

Who is your Doctor? _____

Medication:

[ ] Yes [ ] No Please list any prescription or over-the-counter medication regularly or occasionally taken

_____

Allergies to Medication:

[ ] Yes [ ] No Are you allergic to any medication, aspirin, antibiotics, latex, etc.? (If yes, please list)

_____

Other allergies: (fruit, seafood, cosmetics, etc.)

_____

Women:

[ ] Yes [ ] No Do you have Polycystic Ovarian Disorder?

[ ] Yes [ ] No Is there any possibility that you are pregnant?

Skin Care History:

What is your ancestry? (Irish, English, African, Latin, Indian, Asian, etc.) _____

What is it about your skin you would like to improve: (wrinkles, age spots, broken capillaries, acne, etc.)

_____

List the skin care products you currently use both over the counter and prescription:

_____

_____

[ ] Yes [ ] No Have you had an injury to the face, nose, neck or eyes? (If yes, when?) _____

[ ] Yes [ ] No Do you smoke? If yes, number of packs per day_____ for how long?_____

[ ] Yes [ ] No Do you drink any alcoholic beverages? If yes, number of drinks per day: _____

[ ] Yes [ ] No Have you ever had a cold sore, Shingles or Herpes?

[ ] Yes [ ] No Do you take aspirin or blood thinners?

[ ] Yes [ ] No Do you exercise regularly?

[ ] Yes [ ] No Do you have tattoos or permanent make-up?

[ ] Yes [ ] No Have you had a "reaction" to any anesthetic (Novocaine/Lidocaine) administered by a doctor?

[ ] Yes [ ] No Are you taking or have you taken Accutane? When? _____

[ ] Yes [ ] No Are you using a topical Vitamin A? (Tretinoin, Retin A, Retinoic Acid, Tazorac, Differin, Renova, etc.)

[ ] Yes [ ] No Have you used a tanning bed or been sun bathing in the last week?

[ ] Yes [ ] No Are you using Glycolic Acid/Hydroxy Acid?

[ ] Yes [ ] No Have you ever had an allergic reaction to any skin product or cosmetic? Explain: _____

[ ] Yes [ ] No Are you on hormone replacement therapy?

[ ] Yes [ ] No Do you take birth control pills?

[ ] Yes [ ] No Do you have skin discoloration? (Melasma, light, brown, red, or dark areas)

[ ] Yes [ ] No Do you use sunscreen?

[ ] Yes [ ] No Are you currently under a physician's care for a skin care condition? Explain: _____

Please answer the following:

[ ] Yes [ ] No I accept the fact that there are risks involved in every cosmetic procedure.

[ ] Yes [ ] No I am aware that the possibility exists that my cosmetic treatments may not fully meet my expectations.

[ ] Yes [ ] No I understand that results of my cosmetic treatment are dependent upon full and complete disclosure of all medical and surgical information pertaining to me; and, that omission of issues relating to my health, past surgical history, current medications and allergies, or any other pertinent information may directly affect my personal safety and/or results; and I will follow my post care instructions.

Signed _____ **Date** _____