Vivesse MED SPA

Medical Aesthetic History Form

(Please Print)
Patient Name: _____ _____ ___ Date of Birth:
First Last M _____ Age: _____ M __ F__

Please circle your answers to the questions below. Your answers will assist us in providing you with the best care possible.

Do you have an active infection, fever, flu, cold sores or cold symptoms? Yes No

Have you used medications or herbs that may cause photosensitivity (sensitivity to 515-1200 nm light exposure)? Yes No
(For example, Isotretinoin (Accutane), and tetracycline, St. John's Wort, Doxycline or Retinoin)

In the 3 or 4 weeks prior to treatment, were you exposed to the sun or use artificial tanning creams or sprays? Yes No

Are you planning an event or vacation in the next 3 to 4 weeks that will expose you to the sun? Yes No

Are you pregnant or lactating? Yes No

Do you wear contact lenses? Yes No

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

Do you smoke? Yes No

Do you have a history of any of the following conditions?

Cancer	Yes	No	Erythematosis or Porphyria	Yes	No	Herpes Simplex/Cold Sores	Yes	No
Fear of needles	Yes	No	History of fainting	Yes	No	Amyotrophic Lateral Sclerosis	Yes	No
Blood Disorder	Yes	No	Myasthenia Gravis	Yes	No	Clotting/Bleeding Disorder	Yes	No
Diabetes	Yes	No	Eaton Lambert Disorder	Yes	No	Multiple Sclerosis	Yes	No
Bells Palsy	Yes	No	Liver disease/hepatitis	Yes	No	HIV/AIDS	Yes	No
Anemia	Yes	No	Rosacea	Yes	No	Eczema	Yes	No
Acne	Yes	No	Skin rash or disease	Yes	No	Palpitations	Yes	No
Melasma	Yes	No	Keloids/Excessive scarring	Yes	No	Very dry skin	Yes	No
Psoriasis	Yes	No	Frequent severe headaches	Yes	No	Polycystic ovarian syndrome	Yes	No
Seizures	Yes	No	Tobacco Use	Yes	No	Allergies or sensitivities (gluten etc)		

If you answered yes to any of the above, please provide a detailed explanation in the space below.

_____

Please list and explain other diseases or conditions you have had.

_____

Please list all medications, herbal supplements or over-the-counter medications you are taking.

_____

Do you have any Allergies or/Sensitivities? Yes No **If yes, please explain below.**

_____

Have you ever been treated for a skin condition? Yes No **If yes, please explain below.**

_____

Have you had previous cosmetic procedures? If yes, please check appropriate box.

□ Facials/Peels □ Waxing □ Electrolysis □ Botox □ Depilatories (i.e. Nair) □ Microdermabrasion □ Laser Hair Removal
□ Photo facial □ Sclerotherapy □ Laser Spider Vein □ Dermal filler injections □ Laser facial resurfacing □ Surgery

What Type? When? _____

Skin Tone: □Pale □Light Pink □Medium Pink □Light Olive □Dark Olive □Light Brown □Dark Brown □Soft Black □Black

Patient Signature: _____ Date: _____

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