SYNERGY
MEDAESTHETICS

PRACTICE USE
Date: ___/___/___
Patient ID:_____
☐BP Face ☐BF Body

Full Name: _____ Female / Male Birthdate: ____/____/_____

Address: _____ City, State: _____ Zip: _____

Phone Number: _____ Email: _____

☐ I don't want your bi-monthly e-mail specials

Occupation: _____ Employer: _____ Marital Status: Single / Married / Widowed

Is your partner supportive of potential treatments? Yes / No / Doesn't know I'm here / Not Applicable

How did you hear about us? _____

Main reason for today's treatment? _____

MEDICAL HISTORY

Illnesses/ Chronic Conditions (past & now): _____

Surgery/ Date: _____

Do you currently or have you ever had any of the following? Please circle:

Cold Sores	Hepatitis	Auto Immune Disorder	***Women Only:***
Epilepsy	Diabetes	Hormone Imbalance	Depo-Prevera
Herpes	Pacemaker	Thyroid Condition	Peri Menopausal
Lupus	HIV	Systemic Disease	Birth Control Pills
Migraines	Heart Disease	Neurological Disease	Polycystic Ovaries
Metal Implants	High Blood Pressure	Cancer (past or present)	Hormone Replacement Therapy

PLEASE CIRCLE ALLERGIES & LIST MEDICATIONS:

Shell Fish **Aloe Vera** **Cortisone** **Vitamin C** **Benzoyl Peroxide** **'Caine' Medications**
Iodine **Sunscreen** **Glycolic** **Retinol** **Hydroquinone** **Phenol/Glycerin**
Latex

Other allergies (not listed): _____

Please list all medications: _____

Please circle any of the following skin care/supplemental products you are currently using:

Retin A or Retinol	Glycolic Acid	Vitamin E	Acutane
Renova	Lactic Acid	Exfoliating scrubs	Antibiotics
Differin	Hydroxy Acid	Fish/Flax Oil	Hydroquinone
Adapalene	Vitamin A	Aspirin or NSAIDS	SPF
Tretinoin	Vitamin C	Excederine	Other:_____

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SKIN HEALTH & SERVICES

Smoke tobacco?	Y	N
Exercise regularly?	Y	N
Count calories?	Y	N
Sunbathe outside?	Y	N
Use a tanning booth?	Y	N
Wear SPF 30+?	Y	N
Do you faint easily?	Y	N
Do you flush/turn red easily?	Y	N

Do you have difficulty being numbed at the dentist?	Y	N
Do you have a fear of needles or injections?	Y	N
Have you ever had a chemical peel or microdermabasion?	Y	N
Have you ever had Botox or dermal fillers?	Y	N

Please list any cosmetic surgeries: _____

_____

Caffeinated drinks _____ Day/ Week/Month
Alcoholic beverages _____ Day/Week/Month
Cups of water _____ Day/Week

Do you currently have a skin care routine? And, are you happy with it? _____

What skin care line do you use? _____

Please circle any skin concerns you have:

Dry skin	Fine lines	Dark spots	Large pores	Scaring	Thick skin
Thin skin	Wrinkles	Melasma	Oily skin	Acne scaring	Puffiness
Flaking	Aging	Uneven tone	Whiteheads	Stretch marks	Loose/sagging skin
Rosacea	Redness	Uneven texture	Blackheads	Breakouts/ Acne	Cellulite

Other: _____

Please check the box if the following is true:

- ☐ 1. I want to learn about prescription skin care to correct and prevent lines, wrinkles, and spots.
- ☐ 2. I want to learn about Infini; the non-surgical face and/or necklift.
- ☐ 3. I want to learn about treatment for scaring and/or stretch marks.
- ☐ 4. I want to learn about non-surgical skin tightening & cellulite smoothing for the body.
- ☐ 5. I want to learn about Kybella; the injection to dissolve fat under the chin, or a "double chin".
- ☐ 6. I want to learn about treatment for hyperhydrosis (excessive sweating).
- ☐ 7. I am interested in a custom treatment plan- receiving 4 or more services for a larger price reduction.
- ☐ 8. I want to learn about your monthly membership for aging prevention & regular collagen-building.

Patient signature x_____ Date _____/_____/_____