Patient Information and Medical History

inspire medical spa

Personal Information			
Last Name	First Name		Middle Initial
Address			
City	State		Zip Code
Home Phone	Work Phone		Cell Phone
Email Address			
Date of Birth	Sex	Age	Occupation
How were you referred to us?			

Emergency Contact Information	
Primary Physician	Physician Phone Number
Primary Contact Name & Relationship	Primary Contact Phone Numbers
Secondary Contact Name & Relationship	Secondary Contact Phone Numbers

Medical History I

Please check if you have or have had any of the following:

- ☐ Diabetes
- ☐ Hepatitis
- ☐ Herpes
- ☐ Menopause
- ☐ Sensitive to Anesthetic
- ☐ Lupus
- ☐ Glaucoma (or Family History)
- ☐ Irregular Menses
- ☐ Heart Problems
- ☐ Hysterectomy
- ☐ Hypertension
- ☐ Photosensitive Disorder
- ☐ Autoimmune Illness
- ☐ Bleeding Disorder

Medical History II

Please check and explain if you have or have had any of the following:

- ☐ Keloid Scars _____
- ☐ Hives _____
- ☐ Skin Cancer _____
- ☐ Waxing _____
- ☐ Electrolysis _____
- ☐ Cold Sores _____
- ☐ Hypersensitivity to Skin Products _____
- ☐ Skin Infections _____
- ☐ Tanning Within the Last 6 Weeks _____
- ☐ Use of Acne Products/Drugs _____
- ☐ Chemical Peels _____
- ☐ Photo Sensitizing Substances _____
- ☐ Laser Work of Any Type _____
- ☐ Eye Pressure Problems / Elevated Intraocular Pressure _____

Are you under the care of a Physician?
Are you pregnant?
Do you have any current or recent medical illnesses or conditions not listed above?

Medications

Please list all current and recent medications / vitamins / eye drops etc.

Medications / Vitamins / Eye Drops Include:

-
-
-
-
-
-
-

Medication Allergies

Please list all medication allergies and reactions:

☐ I have no medication allergies

Medication:

Reaction:

Medication:

Reaction:

Medication:

Reaction:

Areas of Interest / Type of Aesthetic Treatment

Please tell us which areas you are interested in treating and the treatment type (Botox / Dysport / Fillers)

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature	**Date**
Printed Name	**Date of Birth**