Ageless Remedies®
med spa & laser 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 Telephone: ( ) ______________ Cell Phone: ( ) _______________ Business Telephone: ( ) ___________

Home Address: ____ **E-Mail Address: _______________________________**

City: _______________________________ State: ___________ Zip: ______________________

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

Spouse's Name: _____________________________________

How would you like us to confirm your appointments? [ ] TEXT MESSAGE [ ] EMAIL

How did you hear about us?

☐ Friend/Family _________________________
☐ Search Engine (Google, Yahoo, MSN)
☐ Social Media (Facebook/Instagram)
☐ Organization__________________________
☐ Gift Certificate
☐ Walk In
☐ Product Website: ______________________
☐ Other _______________________________

Would you like to be featured in our social media posts? [ ] Yes [ ] No

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)

__________________________ __________________________

__________________________ __________________________

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 (including aspirin, Advil, vitamins. etc)?

__________________________ __________________________ __________________________

Allergies to Medications or Other Allergies (fruit, seafood, cosmetics)
[ ] Yes [ ] No Are you allergic to any medication, aspirin, antibiotics, latex etc.? (If yes, please list and explain reaction)

__________________________ __________________________ __________________________

Women:
[ ] Yes [ ] No Do you have polycystic ovary disease?
[ ] Yes [ ] No Is there any possibility that you are pregnant?

Women's Pelvic Health (post-menopausal or childbirth):

[ ] Yes [ ] No Do you experience stress urinary incontinence?
[ ] Yes [ ] No Have you experienced reduced sensation during intercourse?
[ ] Yes [ ] No Do you have vaginal laxity?

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) _________________

____

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? 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 Have you had permanent cosmetics done?
[ ] Yes [ ] No Do you have tattoos?
[ ] Yes [ ] No Have you had a "reaction" to any anesthetic (Novocaine/Lidocaine) administered by a dentist or doctor?
[ ] Yes [ ] No Are you taking or have you taken Acutane? 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 physicians 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 dependant 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**___________________________

Medical Director Richard “Paul” Greenberg, M.D., Ph.D.