Natural Elegance Beauty Medspa
1652 Plum Lane, Suite 103
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909-219-4236
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DEMOGRAPHIC & MEDICAL INTAKE FORM

Name:_____ Date of Birth:_____ Age: _____ Sex: ☐ Female ☐ Male

Address:_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone: _____ Email:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

**By completing this form, you are opting into an automated system to receive occasional reminder/promotional emails and/or text messages. You may unsubscribe at any time.*

How did you hear about us? ☐ Instagram ☐ Facebook ☐ Google ☐ Yelp ☐ Referral (Name of Referral) _____ ☐ Other _____

Please check if you are affected by, or have a history any of the following:

- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Blood/Clotting Disorders
- ☐ Bruise Easily
- ☐ Cardiac Problems
- ☐ Infections (Sinus or Urinary Tract)
- ☐ Diabetes
- ☐ Impaired Healing
- ☐ Epilepsy
- ☐ Fever Blisters/Cold Sores
- ☐ Neurological disorders (ALS, Parkinson's Disease or Myasthenia Gravis)
- ☐ Herpes / Oral Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormonal Imbalance (PCOS)
- ☐ Lupus
- ☐ Keloids/Scarring
- ☐ Hepatitis
- ☐ Pacemaker or Defibrillator
- ☐ Skin Disease
- ☐ Thyroid Issues
- ☐ Cancer
- ☐ Autoimmune Diseases
- ☐ Other:_____

Please list all medications you are currently taking (including herbal, over the counter, topical, oral, and supplemental):

_____

_____

Are you currently: ☐ Pregnant ☐ Trying to get pregnant ☐ Breastfeeding ☐ Taking Birth Control ☐ Taking Antibiotics ☐ Experiencing An Active Infection ☐ Experiencing Active Cold Sores

Do you have any allergies to foods or medications? ☐ Yes ☐ No **Allergies:** _____

Do you have allergies/sensitivities to:

- ☐ Alcohol-Based Products
- ☐ Aloe Vera
- ☐ Aspirin
- ☐ Bee/Wasp Stings
- ☐ Bleaching Agents
- ☐ Bovine/Ovine
- ☐ Eggs
- ☐ Hydrocortisone
- ☐ Hydroquinone
- ☐ Latex
- ☐ Lidocaine
- ☐ Perfumes

Do you consider your skin to be/have:
Check all that apply

- ☐ Normal
- ☐ Dry
- ☐ Oily
- ☐ Blotchy
- ☐ Sensitive
- ☐ Blackheads
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Melasma
- ☐ Psoriasis
- ☐ Redness
- ☐ Patchy Dryness
- ☐ Dehydrated
- ☐ Dark Circles
- ☐ Capillaries
- ☐ Hypopigment
- ☐ Hyperpigment
- ☐ Cysts
- ☐ Acne Scars
- ☐ Breakouts
- ☐ Milia
- ☐ Large Pores
- ☐ Small Pores

Ethnicity
Check all that apply

- ☐ White
- ☐ Asian
- ☐ Hispanic
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ Black

Which of the following best describes your skin when you're in the sun?

- ☐ Always burns, never tans
- ☐ Always burns, sometimes tans
- ☐ Sometimes burns, always tans
- ☐ Rarely burns, always tans
- ☐ Brown, moderately pigmented skin
- ☐ Black skin

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DEMOGRAPHIC & MEDICAL INTAKE FORM- PAGE 2

Do you wear sunscreen? ☐ Yes ☐ No

What skin care products do you use?

_____

Medical/Treatment History:

Have you recently had any of the following:

☐ Anti-Wrinkle Injections
☐ Chemical/Glycolic Peels
☐ Dermal Filler Injections
☐ Facial Depilatory
☐ Facial Waxing
☐ Laser Treatment

If you marked any treatments above, please list treatment & last treatment date(s) below:

_____

Have you recently had any of the following:

☐ Dental Procedures
☐ Surgical Procedures
☐ Flu or other viral illness

If you marked any treatments above, please list date and describe:

_____

Are you currently under the care of a Dermatoligist? ☐ Yes ☐ No

If yes, please list name of doctor:

_____

Ever had facial surgery or facial trauma? ☐ Yes ☐ No

If yes, list date & type of surgery/trauma:

_____

Ever had surgical or non-surgical cosmetic procedures before? ☐ Yes ☐ No

If yes, please list date and describe procedure.

_____

Have you had any medical procedures or immunizations in the past month? ☐ Yes ☐ No

If yes, please list date and describe procedure.

_____

Have you ever had skin cancer? ☐ Yes ☐ No

If yes, list date, location, and type of skin cancer:

_____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often?

_____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day or week?

_____

In the last 10 days, have you taken: ☐ Aspirin ☐ Ibuprofen ☐ Fish Oil ☐ Blood Thinners ☐ Alcohol ☐ Vitamin E

I affirm the above information is accurate to the best of my knowledge.

Patient Name (Print) _____ **Patient Signature** _____ **Date** _____