

BNG Aesthetics

Medical Spa and Laser Center

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PERSONAL INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

How did you hear about us? _____

Do you want to be included on our mailing list? Yes No

If referred by a friend or relative, can you disclose their name so we can thank them for their patronage?

Emergency Contact: _____

Phone #: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Thank you for taking the time to fill out this form.

Medical History Form

PLEASE ANSWER EVERY QUESTION

Name: _____ DOB: _____ Date: _____

- Reason for your visit?
- | | |
|--|--|
| <input type="checkbox"/> Facial lift (MesoLift) | <input type="checkbox"/> Cellulite (MesoCellulite) |
| <input type="checkbox"/> Non-surgical Liposuction (MesoSculpting) | <input type="checkbox"/> Acne or Acne Scars |
| <input type="checkbox"/> Hair Restoration (MesoHair Revivogen) | <input type="checkbox"/> Laser Vein Removal |
| <input type="checkbox"/> Wrinkles or Lip enhancement (Botox or Fillers) | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Skin Rejuvenation, Age Spots,
Sun Damage (Peels or Photofacials) | <input type="checkbox"/> MicroLaserPeel |
| | <input type="checkbox"/> ProFractional Resurfacing |

Have you ever been treated for this problem? _____

How are you currently treating this problem? _____

- Are you currently pregnant or planning to get pregnant? No Yes: _____
- Are you breast feeding? No Yes: _____
- Do you smoke? No Yes: _____
- Do you use drugs? No Yes: _____
- Do you have Diabetes? No Yes...if yes, are you insulin dependent? No Yes
- Do you experience Herpes breakouts (cold sores)? No Yes: _____
- Are you subject to abnormal photosensitivity? No Yes: _____
- Are you subject to excessive scarring (keloid formation)? No Yes: _____
- Do you have any tattoos or permanent makeup? No Yes: _____
- Do you have any allergies (include any drug allergies)? No Yes: _____
- Any history of cancer or chemotherapy? No Yes: _____
- Any bleeding disorders? No Yes: _____
- Any inflammatory skin conditions? No Yes: _____
- Any surgeries? No Yes: _____
- Any heart problems? No Yes: _____
- History of stroke? No Yes: _____
- History of blood clots? No Yes: _____
- Any immune deficiency problems? No Yes: _____
- History of Vitiligo or Porphyria? No Yes: _____
- Lupus, Rheumatoid Arthritis, or Scleroderma? No Yes: _____
- Dizziness, fainting, nervous disorders, heart palpitation? No Yes: _____
- History of hyper or hypo-pigmentation? No Yes: _____
- Any other active skin or general diseases? No Yes: _____

Symptoms (rate each item according to the following scale)

- | | | | |
|-----------------------|-------------------------|-----------------------|--------------------|
| 0 – None | ___ Pimples | ___ Skin Coarseness | ___ Crow's Feet |
| 1 – On Occasion | ___ White Heads | ___ Large Pores | ___ Sun Damage |
| 2 – Barely Noticeable | ___ Black Heads | ___ Scars | ___ Age Spots |
| 3 – Noticeable | ___ Redness | ___ Flushing/Blushing | ___ Varicose Veins |
| 4 – Very Noticeable | ___ Uneven Pigmentation | ___ Fine Lines | |
| 5 – Dramatic | ___ Broken Vessels | ___ Frown Lines | |

Have you ever used Accutane, Retin A, Glycolic Acid, Alpha Hydroxy, Topical Cortisone? No Yes...If Yes, list when and how often? _____

What other medications are you taking (including aspirin)? _____

How often do you consume alcohol? _____

When were you last exposed to the sun, used a tanning booth, or used self-tanner? _____

Are you planning a holiday in the sun? _____

Signature of patient

Skin Typing Matrix

Name: _____

Please answer the following questions by circling the number which best describes you.
Your clinician will total your score during the consultation.

My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	___
	Fair-skinned Caucasians with light hair and light eyes	___
	Pale-skinned Caucasians with dark hair and dark eyes	___
	Olive-skinned (Mediterranean, some Asian, some Hispanic)	___
	Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)	___
	Very dark-skinned (African)	___
My eye Color is:	Light blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light brown	3
	Medium to dark brown	4
	Dark brown - black	5
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6
When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	2
	Within the past week	3

Total Score: _____

If your score is:
0 – 3
4 – 7
8 – 11
12 – 15
16 – 19
20 – 24

Your skin type is:
1
2
3
4
5
6