tre MEDSPA
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NEW PATIENT REGISTRATION AND ASSESSMENT FORM

Today's Date: ________________

Patient Name: ____ ___ Female ___ Male

DOB: ___________________ SSN: ________ - ______ - __________ Occupation: _________________________

Street Address: ____

City, State, Zip: ____

Cell Number: _____________________ Home #: ___________________ Work #: ____________________

□ **Yes, I give permission for Tre Medspa to TEXT me any information on discounts/promos/offers/events.**
□ No, I would rather not receive text for discounts/promos//offers/events.

Email: ____

□ **Yes, I would like Tre Medspa to email me any upcoming specials/promotions/discounts/monthly newsletter.**
□ No, I would rather not receive any emails on discounts/promotions or monthly newsletter.

How did you hear about us? □ Friend: ______________________________ □ Groupon □ Internet Website
□ Tre Medspa Facebook Page □ Local Magazine : ___________________ □ Drive-by/store front

Primary Care Doctor: □ **Dr. Pham next door** □ ____________________________ Dr's. #: _____________

Emergency Contact Name: _____________________________________ Phone #: __________________

If patient is a MINOR, Guardian Name: ________________________________ Ph # ___________________

Specify your genetic origin: □ African American □ Asian □ Caucasian □ Hispanic
□ Mediterranean □ Middle Eastern □ Native American □ Other: ___________________

Answer the following questions: Circle YES or NO

1. Are you currently being treated for any chronic medical conditions? Yes No __________________________
____
2. Do you have any active skin diseases or infection to the area to be treated? Yes No ___________________
3. Are there any abnormal moles with hair in the area to be treated? Yes No ___________________________
4. Have you had any allergic or bad reaction to any topical creams/lotions/ointments in the past? Yes No
____
5. Are you using any retinoid skin products (Retin-A, Renova, Differin, Tazorac, Retinol, Retinaldehyde) currently? If YES, how long has it been since you last used these products? Yes No
____
6. Are you using glycolic/AHA(alpha hydroxyl acid) skin products? Yes No __________________________
7. Do you smoke? If yes, how much do you smoke a day ? Yes No ________________________________
8. Do you use sunscreen daily? What is the SPF on it? Yes No _________________________________
9. Do you use facial depilatories (hair removal devices/treatments)? Yes No ___________________________
10. Do you have hot waxing treatments for hair removal ? Yes No
Area waxed:__________________________ Last time was when?________________________
11. Does your skin remain discolored after healing from a cut or a bite/wound? Yes No
____

 Patient Initials: ______________

PRE-PROCEDURE QUESTIONAIRE/ CONSENT FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS: Circle NO or YES

Are you pregnant ?	**NO**	**YES**
Are you breastfeeding ?	**NO**	**YES**
Are you planning /working on getting pregnant during the course of your treatment?	**NO**	**YES**
Have you had an allergic reaction or bad reaction to the type of treatment or injection that you are scheduled to have today in the past ?	**NO**	**YES**
Do you have any active infection/cuts/abrasions to the area being treated?	**NO**	**YES**
Have you had any recent radiation, chemotherapy, immune system disorder, or uncontrolled diabetes?	**NO**	**YES**
Are you on any blood thinners (Aspirin, warfarin/Coumadin, Eliquis, Xarelto, Brilinta, NSAIDS or others (such as fish oil/omega-3-fatty acids, St. John's wart, gingko biloba, or >400 IU of Vit E in the past week? If YES, name of med:	**NO**	**YES**
Are you allergic to Lidocaine ?	**NO**	**YES**
Are you allergic to Latex ?	**NO**	**YES**
Have you been to any artificial tanning salons/beds or **been exposed to the sun for extended periods of time over the past 2 wks (been to the beach/laying out at pool, etc**? (Disclaimer: Being tanned/exposed to excessive sun just prior to getting certain aesthetic procedures can lead to less effective results, altered results, hypopigmentation to skin/discoloration or unforeseen issues). **If YES, please comment here**:	**NO**	**YES**
Do you have any acute cystic acne or orolabial herpes outbreak present NOW ?	**NO**	**YES**
Do you have a history of orolabial herpes or herpetic outbreak on or near your face?	**NO**	**YES**
Comments:		

**** For patients that are prone to herpetic outbreak to the area of the face that is being treated, it is recommended that they be pre and post -medicated. *** (Please talk to the aesthetician or physician at your consultation visit to see if you may need to obtain a prescription prior to starting any treatment to pre-treat for possible herpetic outbreak).**

List ALL current medications/supplements/herbs here: ________________________________
____
____
____

Are you allergic to any medications? ◻ NO ◻ YES: List name/reaction: ______________________
____

****We are aware that emergencies may arise and appointments may need to be cancelled or rescheduled. We try our best to be understanding. However, after any two consecutive rescheduling or late-cancellations (<24hrs) of an appointment, there will be a <u>$50 charge</u> for any 3rd cancellation or rescheduling of an appointment.**

 Patient Initials: ______________

PAST MEDICAL HISTORY: Please answer YES or NO to any of the questions listed below:

	Do you have a history of the following conditions or issues ?	THIS COLUMN IS FOR OFFICE USE ONLY : **PRECAUTION **	Physician's comments
YES NO	Keloid or Hypertrophic	ALL TX	
YES NO	Eczema/Atopic Dermatitis	Microderm	
YES NO	Does your skin have a tendency to get red/flushed easily?	Microderm	
YES NO	Rosacea	Microderm/chemical peel/Micropeel	
YES NO	Psoriasis, Lichen planus, Vitiligo, Collagen Vascular Disease, Rheumatoid arthritis, Crohn's Disease/Thrombocytopenia	Laser Treatment/MD/CP/MP	
YES NO	Pacemaker	Laser Treatment	
YES NO	On Immunosuppressive therapy or chemotherapy currently, or acute steroid use	Laser Treatment	
YES NO	Diabetes / Liver disease/ Kidney Disease		Caution with all
YES NO	Stroke	Neuromodulators(Botox/Dysport)	
YES NO	Seizures /Epilepsy	Laser Treatment	
YES NO	Skin Cancer :		Any new lesions?
YES NO	Allergic to cow's milk protein, which is a rare condition, (NOT the same as lactose intolerance, which is very common)	Dysport	
YES NO	Anaphylactic shock /severe allergic reactions?	Neuromodulators/Dermal Fillers	
YES NO	HIV infection or acute steroid use?	Need to discuss with physician	Caution with all
YES NO	Nerve disease, ALS, Myasthenia Gravis, Lambert Eaton Syndrome, Bell's Palsy, or stroke?	Neuromodulators (Botox/Dysport)	
YES NO	Lupus, Sarcoidosis, Multiple Sclerosis?	ALL TX	
YES NO	Difficulty swallowing or breathing ?	Neuromodulators (Botox/Dysport)	
YES NO	Do you have an active Urinary Tract Infection or being treated for severe urge incontinence?		Precaution w/ neuromodulators
YES NO	Have you taken **Accutane** in the last 6months?	Laser Treatment	
YES NO	Have you had facial surgery to area of treatment?	Neuromodulators (Botox/Dysport)	

Please indicate which of the following concerns you have about your skin?

- ☐ Age skin
- ☐ Acne
- ☐ Redness
- ☐ Leg spider veins
- ☐ Scarring
- ☐ Sun damage
- ☐ Enlarged pores
- ☐ Wrinkles
- ☐ Unwanted Hair
- ☐ Unevenness to skin
- ☐ Hyperpigmentation
- ☐ Melasma
- ☐ Rosacea
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Oily skin
- ☐ Dry skin
- ☐ Sensitive skin
- ☐ Age spots
- ☐ Texture
- ☐ Hair thinning / Hair Loss
- ☐ Other ____________________________

____

____

Comments: ____

____

If you are looking to do Laser Hair Removal, what area would you like to treat?

☐ Face ☐ Neck ☐ Chest ☐ Arms ☐ Hands ☐ Back ☐ Legs ☐ Other: ________________________

 Patient Initials: ______________

What treatment or procedure(s) might you be interested in today or perhaps in the future ? (mark ALL that may apply, even if you do NOT intend to have the procedure done at this present time)

- □ Facials
- □ Microdermabrasion
- □ Chemical Peel
- □ Laser Hair Removal
- □ Microneedling/Collagen Induction Therapy
- □ **Dysport or Botox**
  - □ Crow's Feet
  - □ Frown line area (Glabellar)
  - □ Forehead wrinkles
  - □ Eyebrow lift
  - □ Pronounced dimpling of chin
- □ Hand rejuvenation
- □ Anti-aging skin rejuvenation treatments
- □ Length/fullness of eyelashes
- □ **Dermal fillers (Restylane or Juvaderm)**
  - □ Lip fullness
  - □ Nasolabial lines (parathesis around the mouth)
  - □ Loss of volume in the cheeks
  - □ Facial fullness/sagging/drooping
- □ Facial redness
- □ Brown spots/age spots/freckles
- □ Scar reduction
- □ Bumpy /blotchy skin complexion
- □ Acne
- □ Spider leg veins
- □ Vascular lesions (such as telangiectasias, port-wine stains)
- □ Hair thinning / Hair Loss

****

Are you interested in getting information on skincare products that may be recommended for your skin type? □ NO □ YES

What brand of skincare products/ line are you currently using? ______________________________

****

What type of cosmetic procedures/treatments have you had in the past? Please document when you had it last.

□ Neuromodulators , which one? □ Botox □ Dysport □ Xeomin :
Last Dose / Injection was when ? ______________________________
How long have you been getting injections all together: ______________________________
□ Dermal fillers (Restylane / Juvaderm / Perlane, others): ______________________________
Last injection was how long ago ? ______________________________
□ IPL (intense pulsed light) or laser treatments: ______________________________
□ Microdermabrasion: ______________________________
□ Chemical Peels: ______________________________
□ Microneedling: ______________________________
□ Laser Hair removal/reduction treatments/procedures: ______________________________
□ Cosmetic surgery : ______________________________
□ Hair Loss Treatments: □ PRP injections in the past □ Hair Transplant □ Others: ______________________________
□ List any medications you are CURRENTLY for hair thinning/loss ? ______________________________
□ List Medications you tried for hair loss in the past : ______________________________
Other : ______________________________
____
____

Did you have any complications or allergic reaction from any of the above treatments in the past ? □ NO □ YES
If Yes: Explain: ______________________________

I acknowledge I have read and answered the above questionnaire and history form to the best of my ability and understand the information provided above will be used to determine my eligibility to receive cosmetic procedures at Tre Medspa. In the event my medical history noted above changes, I understand it is my responsibility to inform Tre Medspa and its staff of these changes in order to properly access and determine if I am a candidate for any cosmetic procedures.

Patient Signature: X ______________________________ **Date:** ____________________

Examiner's Signature: ______________________________ Date: ____________________

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