MG Rejuvenation Center

Hair & Vein Removal • Dermal Fillers • Sun Spot Removal • Botox • Skin Care

Name_____ Today's Date _____/_____/_____
Last First Mo Day Yr

Address:_____ Birth date _____/_____/_____
Mo Day Yr

City:_____ State:_____ ZIP:_____

Best phone number to contact you regarding your treatment and where we may leave a message:

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-mail _____ Who can we thank for referring you? _____

Primary Care Physician _____ PCP Phone Number _____

Please tell us your main concerns that brought you to our office today: _____

_____

_____

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
❑	❑	Are you using any prescribed medications? List_____
❑	❑	Are you using any Herbal medications? List_____
❑	❑	Do you take oral anti-coagulant (blood thinning) medication? List _____
❑	❑	Are you allergic to any cosmetic ingredients, medications or foods? List _____
		_____
❑	❑	Are you pregnant or trying to become pregnant?
❑	❑	Do you use oral contraceptives?
❑	❑	Do you use hormone replacement therapy?
❑	❑	Do you smoke? How much? _____ How long?_____
❑	❑	Do you spend a lot of time outdoors or use a tanning bed?
❑	❑	Do you have any tattoos or permanent makeup? Where?_____

Please check any health problems, past or present:

❑ Seizures	❑ Liver disease	❑ Skin cancer (Type: _____)		
❑ Hormonal Problems	❑ Diabetes	❑ Cystic Acne	❑ Thyroid	❑ Cancer
❑ High Blood Pressure	❑ Heart problems	❑ Collagen	❑ Sarcoidosis	❑ Hepatitis
❑ Vasovagal Syncope	❑ PCOS	❑ Autoimmune (Lupus, Scleroderma)		❑ Asthma

❑ Other:_____

Do you have any of the following chronic skin disorders?

❑ Psoriasis	❑ Dermatitis	❑ Eczema	❑ Keloid Scarring
❑ Fever Blisters	❑ Cold Sores	❑ Sun Blisters	❑ Herpes Simplex/Blisters

❑ Other: _____

In addition to the previous, please tell us which skin conditions concern you the most (Check all that apply):

❑ Uneven skin tone	❑ Visible exposed blood vessels	❑ Hard bumps under skin
❑ Enlarged pores	❑ Clogged pores	❑ Blackheads/Whiteheads
❑ Acne	❑ Excessive oiliness	❑ Pimples
❑ Upper lip lines	❑ Wrinkles	❑ Scarring
❑ Sun Spots	❑ Dry patches	❑ Unwanted Hair
❑ Sun Damage	❑ Brown spots (Hyper-pigmentation)	❑ White spots (Hypo-pigmentation)

What is your skin type: ❑ Dry ❑ Combination ❑ Oily ❑ Normal

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

❑ Cleanser _____	❑ Soap _____	❑ Toner _____
❑ Moisturizer _____	❑ Night Cream _____	❑ Mask _____
❑ Eye cream _____	❑ Astringent _____	❑ Glycolic Cleanser _____
❑ Scrub _____	❑ Sunscreen_____	❑ Salicylic Cleanser _____
❑ Vit. A Cream _____	❑ Vit. C Cream _____	❑ Alpha or Beta hydroxy Cream _____

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyper pigmentation?

Please list_____
_____

Have you ever had any of the following wrinkle fillers or implants?

❑ Collagen ❑ Restylane ❑ Perlane ❑ Hylaform ❑ Juvederm ❑ Silicone ❑Radiesse
❑ Sculptra ❑Other:_____

* If so, when? _____ What area? _____ By whom? _____

Have you ever undergone any of the following treatments?

❑ Cosmetic Surgery
What area of the body? _____
When and where was it done? _____
❑ Botox
What area of the face? _____
When and where was it done? _____

❑ Acid Peel ❑ Accutane ❑ Micro-dermabrasion ❑ Lasers
When and where was it done? _____

Are you currently removing hair by any of the following methods?

❑ Waxing ❑ Tweezing ❑ "Nair" type products ❑ Electrolysis ❑ Laser Hair Removal

*If so, when?_____ What area?_____ What type of laser?_____

I certify that the above information is correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history.

_____ _____
Patient's Signature **Date**