Guest Health History Form

Personal Information:

First Name_____Middle_____Last_____

Address_____

City_____ State_____ Zip Code_____

Home Phone# (_____) _____-_____ Cell# (_____) _____-_____

Date of Birth_____/_____/_____ Age: _____ Male Female

E-mail Address_____ @_____-_____

Emergency Contact _____ Phone# (_____) _____-_____ Relationship_____

If Guest is under 18 years of age, Guardian Name:
_____

How did you hear about us? Circle one:
Family member, Friend: Name _____
Frisco Style, Snapchat, Instagram, Facebook, Yelp, Real Self, Google, Dallas Cowboy Cheerleaders Other:
_____

Reason for visit:
_____

For your safety and well-being, we would like you to answer a few health-related questions. This information will remain confidential.

What are your concerns? Please check all that apply

- ☐ Irregular tone
- ☐ Rough texture
- ☐ Fine lines
- ☐ Wrinkles
- ☐ Sun damage & brown spots
- ☐ Facial vessels
- ☐ Underlying redness
- ☐ "Turkey Neck"
- ☐ Jaw line
- ☐ Saggy skin
- ☐ Melasma
- ☐ Acne
- ☐ Stretchmarks
- ☐ Thighs
- ☐ Arms
- ☐ Wrinkles on forehead
- ☐ Frown lines between eyebrows
- ☐ Crow's feet on eyes
- ☐ Bunny lines on nose
- ☐ Wrinkles above lip
- ☐ Down turned mouth
- ☐ Thin lips
- ☐ Laugh lines
- ☐ Dark circles under eyes
- ☐ Under eye bags
- ☐ Acne scars
- ☐ Abs
- ☐ Vaginal rejuvenation

Have you ever taken Accutane? Yes ☐ No ☐

If yes, when? _____

Do you have a history of cold sores? Yes ☐ No ☐

If yes, how frequent? _____

Do you use Retinol creams, Retin-A, or other topical preparations? Yes ☐ No ☐

If yes, please explain _____

Do you have any problems healing from a cut or burn? Yes ☐ No ☐

If yes, please explain _____

Have you ever had facial peels, laser, surgery or dermabrasion? Yes ☐ No ☐

If yes, please explain _____

Do you work/play in the sun? Yes ☐ No ☐

If yes, please explain _____

Do you use sun protection daily? Yes ☐ No ☐

Do you use tanning beds? Yes ☐ No ☐

Are you currently under the care of or have you ever been treated by a Medical Physician for any significant illness other than colds, flu or virus? If so, please explain:

_____

Current Height _____ Current Weight _____

Are there any significant illnesses or cancer that runs in your family? Please provide details:

_____

_____

Have you had any surgical procedures? Please provide details:

_____

_____

SOCIAL HISTORY:

Alcohol Use: Never _____ Occasional _____ Drinks per week _____
Do you Smoke Cigarettes: Yes ☐ No ☐ If yes, how many per day? _____
Do you use smokeless tobacco: Yes ☐ No ☐

CURRENT MEDICATIONS:
(Include herbs, vitamins & any other over-the-counter medications.)

Aspirin	Yes ☐	No ☐
Oral Contraceptives	Yes ☐	No ☐
Blood Thinners	Yes ☐	No ☐

Name of Medication	Dosage	Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergies to Medications? if YES, please specify:

Penicillin	Yes ☐	No ☐	_____
Local Anesthesia	Yes ☐	No ☐	_____
Any others	Yes ☐	No ☐	_____

Women Only

Pregnant?	Yes ☐	No ☐	Lactating?	Yes ☐	No ☐
Premenstrual breakouts?	Yes ☐	No ☐	Birth control pills?	Yes ☐	No ☐

☐ ***Yes! I would like to receive Atomic Beauty's bi-monthly e-newsletter.***

Spa services are not covered by insurance. It is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility at the time of service.

The undersigned having read and understood the terms herein, executed this:

_____ _____
Patient Signature Date

_____ _____
Witness Date