FUSION
MEDICAL SPA
& WELLNESS

Wellness Treatment Intake Form

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Demographics:

Name_____ Date_____

Date of Birth_____Age_____ Sex: ☐ Male ☐ Female

Mailing Address_____

Physical Address_____

City_____ State_____ Zip Code_____

Home Phone _____Cell Phone ___ _____

E-mail address_____

We will call to confirm your scheduled appointment. Preferred contact number:_____

Occupation_____ Employer_____

Who can we thank for your referral?_____

Emergency Contact: _____Phone: _____

Relationship:_____

Family Physician or Health Care Provider Name: _____

Dermatologist Name: _____

Aesthetic/ skin concerns: _____

Main reason for visit: _____

Are you happy with the way you're aging? _____

If not what area _____

Are there any other concerns you would like to discuss? If so please list.

_____

_____

Medical History:

Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Herpes ☐ Arthritis ☐ Cold sores ☐ HIV/AIDS

☐ Skin disease/Skin lesions ☐ Seizure disorder ☐ Hepatitis Thyroid disease

☐ Blood clotting abnormalities ☐ Any active infection ☐ Sleep Apnea

Do you have any other health problems or medical conditions? Please list: _____

_____

Allergies:

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced). Medications: ☐ Latex Lidocaine (other local anesthetics)

☐ Hydroquinone or skin bleaching agents Others: _____ ☐ No Known Allergies

If so, please list and describe the reaction: _____

Medications:

What medications are you presently taking? _____

_____

Have you ever used Accutane? ☐ Yes ☐ No, If yes, when did you last use it? _____

What topical medications or creams are you currently using? ☐ Retin-A® ☐ Others (Please list): ___

_____

What herbal supplements or vitamins do you use regularly? _____

_____

Surgical History:

Please list your past surgical procedures or hospitalizations and their date: _____

_____

_____

_____

_____

Aesthetic History

Do you smoke? ☐ Yes ☐ No

Do you wear sunscreen daily? ☐ Yes ☐ No

Do you regularly use tanning salons or sun bathe? ☐ Yes ☐ No

Have you had any recent tanning or sun exposure that changed the color of your skin? ☐ Yes ☐ No

Have you recently used any self-tanning lotions or treatments? ☐ Yes ☐ No

Have you ever had laser hair removal? ☐ Yes ☐ No

Have you used any of the following hair removal methods in the past six weeks?

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing ☐ Stringing ☐ Depilatories

Have you had any other laser procedures before? ☐ Yes ☐ No

If yes, please list them and their date:_____

Do you form thick or raised scars from cuts or burns? ☐ Yes ☐ No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ Yes ☐ No If yes, please describe: _____

Have you ever had BOTOX injections? ☐ Yes ☐ No If yes, how long has it been since your last injection?_____

Have you ever had injectable fillers? ☐ Yes ☐ No If yes, how long has it been since your last injection?_____

If you could change one thing about your appearance what would it be?

_____

For our female clients:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

What are you currently using for contraception?_____

Do you have regular periods? ☐ Yes ☐ No

I certify that the preceding medical, personal and skin history statements are true and 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. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____