BASILE MediSpa

NEW **MediSpa** PATIENT REGISTRATION

Name:____ Date:____________
Address:____ Age:_____________
_____________________________________ Date of birth: _____________
Home Phone:__________________ Cell Phone__________________________________
Email :________________________@____________Emergency contact_______________

How were you referred to us?: friend / print ad / website / Doctor/ you're a surgery patient

What **areas/ topics** will we discuss today?

O BASIC SKIN CARE
O SPECIFIC FOCUS (circle as needed)

FACE		NECK		BODY	
	Wrinkles		Wrinkles		Wrinkles
	Texture		Texture		Texture
	Color		Color		Color
	Looseness		Looseness		Looseness
	Hair		Hair		Hair _____________
	Acne		Infection		_____________
	Rosacea		Other_____________		Infection
	Other_____________				Other_____________

Have you ever had treatments with?:		most recent application (date)
Botox	Y / N	___________
Restylane	Y / N	___________
Collagen	Y / N	___________
Hylaform	Y / N	___________
Radiesse	Y / N	___________
Juvederm	Y / N	___________
Other __________________		___________

Medical History (check which apply)		Surgical history (check which apply)	
	High blood pressure		Brow lift
	Bleeding tendencies		Eyelids
	Heart disease		Midface lift
	Diabetes		Facial implants
	Migraines		Face lift
	Arthiritis		Neck lift
	Fever blisters/cold sores		Liposuction of face/neck
	Neurologic disease		Lip augmentation

Are you pregnant or nursing?	Y / N	
Do you hav any active infections?	Y / N	
Do you smoke cigarettes?	Y / N	
Do you take aspirin, ibuprofen, or blood thinners?	Y / N	
Do you have any medical allergies?	Y / N	list please:_________________________
Do you develop fever blisters/cold sores?	Y / N	

Please list any medications you take regularly: ____

Signed______________________________________ Thank you.

The information you have provided is essential in our comprehensive evaluation of your goals. ~Andrea Basile, MD