Restoration Medspa at
Associates in Plastic Surgery, Inc.

First Name: _____ Last Name: _____

Date: _____ Date of Birth: _____ Age: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ **Preferred Contact #** _____

How did you hear about us? _____ Is it important to be discreet? (Y/N)

☐ Check this box if you wish to be on our mailing list to receive special offers and updates.

Describe the Nature of your visit: _____

What are your expectations: _____

Lifestyle

Rate your level of stress on a scale of 1-10 (10 being the highest)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does stress affect any of the following?
☐ Skin ☐ Digestion ☐ Breathing ☐ Sleep ☐ Health ☐ Muscle Tension

What is your daily consumption of the following?
☐ Water _____ ☐ Soda _____ ☐ Alcohol _____ ☐ Coffee _____ ☐ Tea _____ ☐ Other _____

What do you do to relieve stress? _____

How many hours of sleep do you average? ☐ 4-6 ☐ 6-8 ☐ 8-10

Do you smoke? ☐ Never ☐ 1- 20 Daily ☐ 20 + Daily Do you exercise? ☐ Yes ☐ No Frequency? _____

Are you currently on a Weight Loss Program: ☐ Yes ☐ No If so, Please give details: _____

_____

What are your current skin care products and home care regimen? _____

_____

Are you currently using any of the following? ☐ AHA's ☐ Retin A ☐ Hydroquinone Bleach

Do you experience any of the following?

Face:	☐ Dryness	☐ Sensitivity	☐ Broken Capillaries	☐ Fine lines	☐ Sun Damage
	☐ Puffy Eyes	☐ Dehydration	☐ Oiliness	☐ Rosacea	☐ Scaring
	☐ Dark Circles	☐ Acne	☐ Breakouts	☐ Decreased Elasticity	
	☐ Burns	☐ Product Allergies	☐ Pigmentation/Age Spots		
Body:	☐ Muscle Pain/Cramps	☐ Sluggish Digestion	☐ Cellulite	☐ Weight Gain	☐ Insomnia
	☐ Fluid Retention	☐ Poor Circulation	☐ Lethargy	☐ Difficulty Relaxing	☐ Dry Skin
	☐ Muscle Tone				

Medical History

Have you use Accutane, AHA's or had Laser Treatment?

☐ Yes ☐ No _____

Are you on any medication or under medical supervision?

☐ Yes ☐ No _____

IS there a history of family illness?

☐ Yes ☐ No _____

Have you suffered from any recent shock?

☐ Yes ☐ No _____

Have you suffered from any sports injuries or sprains / fractures in the last 2 years?

☐ Yes ☐ No _____

Have you had any recent cosmetic surgeries, surgery or accidents?

☐ Yes ☐ No _____

Have you been treated for cancer in the last 5 years?

☐ Yes ☐ No _____

Are you less than 6 weeks postnatal, pregnant or planning a pregnancy?

☐ Yes ☐ No _____

Have you experienced any Gynocological problems?

☐ Yes ☐ No _____

Are you Breastfeeding?

☐ Yes ☐ No _____

Have you had a Hysterectomy?

☐ Yes ☐ No _____

Do you have any of the following?

☐ Allergies	☐ Diabetes (insulin controlled)	☐ High/Low Blood Pressure	☐ Muscular Dystrophy
☐ Arthritis	☐ Epilepsy/seizure	☐ Hyperthyroid	☐ Pacemaker
☐ Asthma	☐ Fibromyalgia	☐ Iodine (Seaweed) Allergy	☐ Psoriasis, Eczema, Dermatitis
☐ Claustrophobia	☐ Headaches	☐ Irritable Bowel Syndrome	☐ Renal & Liver Disorders
☐ Constipation	☐ Heart Condition	☐ IUD Coil (copper 7 only)	☐ Rheumatism
☐ Contact Lenses	☐ Hernia	☐ Metal Pins & Plates	☐ Swelling
☐ Depression	☐ Herpes (cold sore)	☐ Migraines	☐ Sunburn
☐ Tuberculosis	☐ Thrombosis	☐ Varicose Veins	

Comments: _____

Medical History
Please fill out any of the following that may apply:

Keloids ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Heart Condition ☐ Yes ☐ No
Cold Sores/Herpes ☐ Yes ☐ No	Pregnant/Lactating ☐ Yes ☐ No	Perm Makeup/Tattoos ☐ Yes ☐ No	Systemic Disease ☐ Yes ☐ No

Include any other medications that make you photosensitive:

_____

List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin, etc.)

_____

Any allergies:

_____

Check other services of interest:

__ Laser Hair removal (list different areas of interest)

_____

__ Laser vein removal
__ Non-Ablative Laser Facial
__ Pigmented Lesions or Brown Spot removal
__ Other:

_____

Skin Background:

Have you had prolonged sun exposure (or tanning) in the past 3 days? ☐ Yes ☐ No
Is so, are you currently sunburned? ☐ Yes ☐ No
Do you use tanning beds? ☐ Yes ☐ No
Are you using chemical tanning solutions? ☐ Yes ☐ No
Do you use sunscreen on a regular basis? ☐ Yes ☐ No

Acne:

Do you have a history of breakouts? ☐ Yes ☐ No
If so, what is the frequency of your breakouts? ____Frequent ____ Occasional ____ Rarely
Do you have cystic breakouts? ☐ Yes ☐ No
Do you have any scarring as a result of your acne? ☐ Yes ☐ No

Skin Type:

Caucasian ☐ Yes ☐ No
Hispanic ☐ Yes ☐ No
Mediterranean ☐ Yes ☐ No
African American ☐ Yes ☐ No
American Indian ☐ Yes ☐ No
Pacific Islander ☐ Yes ☐ No
Other _____

Have you waxed, used depilatories, bleaches or other chemical process? ☐ Yes ☐ No
Have you had microdermabrasion? ☐ Yes ☐ No
Have you had any chemical peels? ☐ Yes ☐ No
Have you had laser resurfacing? ☐ Yes ☐ No
Have you had Botox or Filler injections in the past 6 months? ☐ Yes ☐ No
If less than 3 months, approximate dates? _____

I certify that the above medical history information is accurate and correct:

Patient Signature: _____ Date: _____

Dr. / Tech Signature: _____ Date: _____

Genetic Disposition Score	0	1	2	3	4
What is the color of your eyes?	☐ Light Blue, Gray, Green	☐ Blue, Gray or Green	☐ Blue	☐ Brown/ Hazel	☐ Brownish Black
What is the natural color of your hair?	☐ Sandy Red	☐ Blond	☐ Chestnut/ Dark Blond	☐ Brown	☐ Black
What is the color of your skin(non exposed areas)?	☐ Pink/Reddish	☐ Very Pale	☐ Pale with Beige tint	☐ Light Brown/Olive	☐ Dark Brown
Do you have freckles on Unexposed areas?	☐ Many	☐ Several	☐ Few	☐ Incidental	☐ None

Reaction to Sun Exposure Score	0	1	2	3	4
What happens when you stay in the sun too long?	☐ Painful, redness, blistering, peeling	☐ Blistering followed by peeling	☐ Burns sometimes followed by peeling	☐ Rarely burns	☐ Never have burns
To what degree do you turn brown?	☐ Hardly or not at All	☐ Light color tan	☐ Reasonable tan	☐ Tan very easy	☐ Turn dark brown quickly
Do you turn brown within Several hours after sun exposure?	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
How does your face react to sun?	Very Sensitive ☐	Sensitive ☐	Normal ☐	Very Resistant ☐	Never had a problem ☐

Tanning Habits Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamps/tanning creams)?	More than 3 months ago ☐	2-3 months ago ☐	1-2 months ago ☐	Less than 1 month ago ☐	Less than 2 weeks ago ☐
Do you expose the area to be treated to the sun?	Never ☐	Hardly ever ☐	Sometimes ☐	Often ☐	Always ☐

Total Score: Genetic Disposition: ☐
Total Score: Reaction to Sun: ☐
Total Score: Tanning Habits: ☐

Total: Skin Type Score ☐

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI