BLU·ICE
MED SPA

Client Medical History

Name:____ **Today's Date**_______________

DOB:____________ **Occupation:**________________ **Preferred Pharmacy:**______________

Home Address:____

City:____________________ **State:**_____ **Zip Code:**_________

Cell Phone: (_____)________ **Email Address:** ______________________

Emergency Contact Name and Phone:_____________________________________

Do you want to be notified by email of Blu Ice's upcoming events and promotions? **YES** **NO**

How Did you hear about us? **Google Search** **FaceBook** **Instagram**
Drive By **Referral**___________________

Procedures / products of interest to you:

___ **Botox Cosmetic (Botulinum Toxin Type A)**

___ **Derma Fillers (Juvederm, Radiesse, Voluma, Sculptra)**

___ **Skin Care Advice**

___ **Sunscreen Advice**

___ **Chemical Peels**

___ **Collagen Therapy**

___ **Avage, Retin-A or Renova**

YES	**NO**	**Do you smoke?**
YES	**NO**	**Do you get regular exercise? Type:**____________
YES	**NO**	**Scleroderma or other connective tissue disease?**
YES	**NO**	**Are you on immunosuppressive therapy?**
YES	**NO**	**Have had radiation therapy?**
YES	**NO**	**Bleeding problems:**
YES	**NO**	**Breathing problems, such as asthma or emphysema?**
YES	**NO**	**Drooping eyelids? (other than natural aging)**

YES NO Do you have a history of any eye pressure problems/macular edema?

YES NO have a pacemaker or internal defibrillator?

YES NO Herpes infections, bacterial or fungal infections in the areas to be treated?

YES NO History of epilepsy?

YES NO Side effects from any Botulinum toxin product in the past?

YES NO Do you form thick or raised scars (keloids) from cuts or burns?

YES NO Hyper-pigmentation (darkening of the skin) or Hypo-pigmentation (lightening of the skin?

YES NO Areas of persistent redness?

YES NO Are you using medications that make you sensitive to light?

YES NO Are you using preparations containing sulfur, resorcinol, or salicylic acid?

YES NO Do you have a history of anaphylaxis/severe allergies?

Women Only:

YES NO Are you using contraception?

YES NO Pregnant or plan to become pregnant?

YES NO Breast feeding or plan to breastfeed?

YES NO Do you experience incontinence? ex. Leakage when you jump, laugh, or sneeze

YES NO Do you have decreased sensation with intercourse?

If you circled yes to any of the above, please explain here:____

____

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 aesthetician, therapist, nurse or doctor of my current medical/health conditions and to update this history if and when needed. I understand that there are no refunds for any services or products. By signing below I authorize BluIce Medspa to take photos/videos of me which may be used for marketing and promotional purposes.

Patient Signature:____________________________ **Date:**__________

Reviewed by:________________________________ **Date:**__________

Client Medical Updates:

Client ID #: ____________________

Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________

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