



CLIENT PROFILE & HEALTH HISTORY

Last Name: First: Middle:

Email Address: Birth Date: Age: Sex: Male Female

Street Address: Home Phone: Mobile Phone: Work Phone: Please Circle Preferred Contact Number

P.O. Box: City: State: Zip:

Occupation: Employer:

Ethnicity: Caucasian Hispanic Asian African American Middle Eastern Mediterranean Other

How did you hear about Us?

Emergency Contact: Relationship: Phone:

ARE YOU ALLERGIC TO SOY? YES NO

Do you have any other Allergies:

Do you have any history of allergies to medications in the "caine" family (i.e. Lidocaine, Novacaine, Etc.) YES NO

Please Check All That Apply:

- Are You Pregnant? Breastfeeding? Date of Last Menstrual Preiod? Alcohol? How Many Per Week?
Suffered a Stroke? Smoker? How Many Per Day? Date of Last Aspirin, Advil, Excedrin, Etc?
Anxiety Asthma Autoimmune Disease Bleeding Disorder Blood Diseases Bruise Easily
Cancer Diabetes Endocrine Disorder Glaucoma Heart Dsease Hepatitis
Herpes Hypertension High Cholesterol HIV HRT Infections
Jaundice Liver Disease Low Blood Pressure Melasma Menopause Neurological
Psoriasis Pulmonary Disease Renal Disease Seizures Shingles Tattoos
Thyroid Disorder Vitiligo Blood Clots History of Eanting Disorders Other

Current Medications, Vitamins, or Herbal Renedies:

Are you being treated for any Medical Conditions? If yes, please list:

Surgical History:

Primary Care Physician: Phone Number:

Check Area/Areas of Intrest: Botox Fillers Skin Rejuvenation

Other Skin Care (Microdermabrasion/ Chemical Peels)

Laser Hair Reduction Area(s):

I am willing to be contacted by The MedSpa at Bad Hair Day?, or its agents about opportunities to be interviewed by the media about my treatment and results. Yes No

Patient Signature Date Kelly King, MD Date