South Bay Plastic Surgeons

MEDICAL SPA HEALTH QUESTIONNAIRE

Name_____ Date of birth_____
Referred by_____

List all current daily medications (include vitamins, herbs, and over-the-counter medicines):

_____ _____ _____
_____ _____ _____

List all allergies:_____

Please answer the following questions regarding your medical history:	Yes	No
Have you ever taken Accutane?	☐	☐
Have you used Tretinoin or Retin-A?	☐	☐
Do you take oral birth control or other hormonal supplements?	☐	☐
Are you pregnant?	☐	☐
Are you breast feeding?	☐	☐
Are you attempting pregnancy	☐	☐
Do you have Herpes Simplex or cold sores?	☐	☐
Do you have any skin disorders?	☐	☐
Do you regularly take Aspirin, Motrin, Omega 3, Vitamin E, or steroids?	☐	☐
Do you have a history of anemia or bleeding?	☐	☐
Do you have high blood pressure?	☐	☐
Do you have Polycystic Ovary Disease (PCOD)?	☐	☐
Do you have any muscle or nerve conditions (such as amyotrophic lateral sclerosis, myasthenia gravis, or Lambert-Eaton syndrome)?	☐	☐

Have you received the following treatments in the past?

Botox	Yes	No	When was your last treatment?_____
Fillers	Yes	No	When was your last treatment?_____
Cosmetic Surgery	Yes	No	Please specify:_____
Facials/Peels	Yes	No	Please specify:_____
Laser	Yes	No	Type of laser treatment: IPL, laser hair removal, laser vein, CO2, Fotofacial

Please describe any negative reactions to previous procedures:_____
_____

Which skin care products are you currently using?_____
_____

I certify that I have disclosed my medical history to the best of my knowledge.

_____ _____
Patient Signature Date Provider Signature Date

Charles W. Spenler, MD, FACS Michael K. Newman, MD Lisa L. Jewell, MD, FACS

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