DÉJÀ VU MEDSPA

Health Information Questionnaire

Name:_____ Date of Birth:_____

Address:_____ City & Zip: _____

Home Phone:_____ Email:_____

Cell Phone:_____ Carrier:_____
(This will enable us to send SMS appointment reminders)

How did you hear about us? _____

Have you ever had any of the following conditions?
Check all that apply:

_____ Alcohol Use
_____ Anemia
_____ Arthritis
_____ Auto Immune Deficiency
_____ Asthma
_____ Blood Disease
_____ Chemotherapy (active)
_____ Cholesterol Problems
_____ Diabetes
_____ Dizziness/Fainting
_____ Epilepsy
_____ Headaches
_____ Heart Disease
_____ Hepatitis
_____ High Blood Pressure
_____ HIV/AIDS
_____ Infection
_____ Kidney Disease
_____ Liver Disease
_____ Lupus
_____ Melanoma
_____ Mental/Nervous Disorder
_____ Obesity (family history)
_____ Pacemaker
_____ Radiation Therapy
_____ Respiratory Problems
_____ Skin Conditions
_____ Sinus Problems
_____ Smoking
_____ Stroke
_____ Thyroid Problems
_____ Tuberculosis
_____ Ulcers
_____ Venereal Disease

Allergies: _____
Medications _____
Cosmetics _____
Latex/Other: _____

Have you ever/are you currently using:			If yes, when?
Retin-A Renova, any retinoic acid product	No	Yes	_____
Accutane	No	Yes	_____
Prescription Acne Medication	No	Yes	_____
Birth Control Pills/Patch	No	Yes	_____
Steroids	No	Yes	_____
Are you pregnant?	No	Yes	
Due Date? _____			
Are you lactating?	No	Yes	

Previous Cosmetic Facial Treatments:				
Acid Peel	No	Yes	Date	_____
Botox	No	Yes	Date	_____
Collagen	No	Yes	Date	_____
Tattoo/Perm Makeup	No	Yes	Date	_____
Waxing	No	Yes	Date	_____
Facial Surgery	No	Yes	Date	_____
Laser Surgery	No	Yes	Date	_____
Microderm Abrasion	No	Yes	Date	_____

Have you ever had:

Cold Sore	Yes	No		
Fever Blister	Yes	No		
Frequency	<1/year	1-3/year	4+/year	

List all current medications/supplements that you are taking:

_____

_____

_____

Have you been tanning in the last 2 weeks? Yes No

List any questions that you have: _____

_____

What Procedures are you interested in?

Check all that apply:

Anti-Cellulite Therapy

_____ Acoustic Wave Therapy

Microdermabrasion

_____ Face
_____ Chest
_____ Hands

Skin Rejuvenation & Wrinkle Reduction

_____ Full Face
_____ Forehead
_____ Lower Face
_____ Nose
_____ Neck
_____ Face and Neck
_____ Hands

Laser Acne Treatment

_____ Full Face
_____ Upper Back
_____ Complete Back
_____ Chest

Acne Scar Reduction

_____ Face
_____ Body

Stretch Mark Reduction

_____ One Area
_____ Multiple Areas

Photo Facial, Spots, and Spider Veins

_____ Full Face
_____ Neck
_____ Hands
_____ Décolletage
_____ Single Shot Spots
_____ Spider Veins

Medical Grade Cosmeceuticals

_____ Jan Marini (anti-aging)
_____ OBAGI (acne treatment)
_____ OBAGI

Body Treatments

_____ Wraps
_____ Full body Scrub
_____ Massages

Botox

_____ Forehead
_____ Nose
_____ Eyes

Injectables

_____ Juvederm
_____ Lipodissolve

Laser Hair Removal

_____ Please list areas needing treatment. (lower eyebrow is the only untreatable area)

_____
_____
_____

Body Contouring

_____ Vybe Plate
_____ Slim Dome
_____ Anti-Cellulite Therapy
_____ Lipotherme (Laser Lipo)

Weight Loss Clients Only:

Exercise Habits:

How many times per week? _____
How long are your workouts? _____
Do you weight train? _____
Do you perform cardio? _____

Have you used medications for weight loss?

No _____ If yes, when: _____

Female Clients: (please initial)

I am not pregnant _____
I will notify office if I become pregnant _____

I acknowledge that I have completed the Health Information Questionnaire accurately and to the best of my knowledge.

_____ _____
Signature Date

Your Person Skin Type Evaluation

Skin Type _____ Normal _____ Oily _____ Dry _____ Combination _____ Other

Condition _____ Texture _____ Sun Damage _____ Acne _____ Pigment problems
_____ Sensitivity _____ Other:_____

Sunburn Sensitivity _____ Always _____ Occasionally _____ Usually _____ Rarely _____ Never

Specific Areas of Concern?_____

Your Personal Wrinkle Evaluation

Glogau's Classification of Photo Aging Groups

Please circle what group you feel you fall into.

Group I	Mild (usually 28-35 years old) No keratoses Little Wrinkling No scarring Little or no makeup
Group II	Moderate (usually 35-50 years old) Early actinic keratoses (slight yellow discolorations) Early wrinkling Parallel smile lines Mild scarring Little makeup
Group III	Advanced (usually 50-60 years old) Actinic keratoses (obvious yellow skin discoloration with telangiectasis) Wrinkling- present at rest Moderate acne scarring Wears makeup always
Group IV	Severe (usually 60-70 years old) Actinic keratoses and skin cancers have occurred Wrinkling- much cutis laxa of actinic gravitational and dynamic origin Severe acne scarring Wears makeup that is caked on

Other Photo Aging Concerns:

- Anticoagulant medication and aspirin as it increases chance of bruising post treatment
- Seizure disorders triggered by light
- Medications that may cause photosensitivity or medications within or above wavelength range (e.g. non-steroidal anti-inflammatory products)

Your Personal Skin Type Evaluation

Fitzpatrick Classification for Skin Types

Please circle what group you feel you fall into.

Skin Type	Color	Reaction to UV	Reaction to Sun
Type I	Caucasian; Blond or red hair, freckles, fair skin blue eyes	Very sensitive	Always burns easily, never tans, very fair skin tone
Type II	Caucasian; Blond or red hair, freckles, fair skin blue or green eyes	Very sensitive	Usually burns easily, tans with difficulty, fair skin tone
Type III	Darker Caucasian light Asian	Sensitive	Burns moderately, tans gradually, fair to medium skin tone
Type IV	Mediterranean, Asian, Hispanic	Moderately sensitive	Rarely burns, always tans well, medium skin tone
Type V	Middle Eastern, Latin, light skinned African-American, Indian	Minimally sensitive	Very rarely burns, tans very easily, olive or dark skin tone
Type VI	Dark skinned African-American	Least Sensitive	Never burns, deeply pigmented, very dark skin tone

Genetic Disposition:

Please circle what boxes you feel best describes your natural state.

Score	**0**	**1**	**2**	**3**	**4**
Natural Eye Color	Light Blue, Green or Grey	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
Natural Hair Color	Sandy, Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
Color of Non-Exposed Skin	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas	Many	Several	Few	Incidental	None

Total Score:_____

####

Your Personal Skin Type Evaluation

Fitzpatrick Classification for Skin Types

Reactions to Sun Exposure:
Please circle what boxes you feel best describes your natural state.

Score	0	1	2	3	4
What happens when you stay in the sun to long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burn, sometimes followed by peeling	Rarely burn	Never burn
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonably tan	Tan very easily	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 the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total Score:_____

Tanning Habits
Please circle what boxes you feel best describes your natural state.

Score	0	1	2	3	4
When did you last expose your body to sun or tanning booth/cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Score:_____

Summary

Add up the total scores for each of the previous sections:

Genetic Disposition _____
Reaction to Sun Exposure _____
Tanning Habits _____

Total Score _____

Your Fitzpatrick Skin Type:

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