Beauty Bodyworks Patient Information

Date:_____
Name:_____DOB:_____
Home #:_____ Cell #:_____
Email: _____
Address:_____ City:_____ State:_____ Zip:_____
Skin Goals / Body Improvements:_____
Reason for visit:_____
Emergency Contact:
Name:_____ Relationship:_____
Address:_____ Telephone #:_____

Medical & Surgical History:

Allergies: Do you have any allergies to drugs, medications or foods? __Yes __No
If yes, please list below and give type of reaction:

_____
_____

Medication: Are you taking any medication for any of the following conditions?

Condition	**Yes**	**No**	**Medication**
Blood Thinner	__	__	_____
Pace Maker / Other	__	__	_____
High Blood Pressure	__	__	_____
Diabetes	__	__	_____
Anemia	__	__	_____
Sleep	__	__	_____
Heart Disease	__	__	_____
Thyroid	__	__	_____
Herpes/ Cold Sores/ Fever Blisters	__	__	_____
Retin-A	__	__	_____
Antibiotics	__	__	_____
Other:	__	__	_____
History of cold sores/herpes:	__	__	

If yes, we need to prescribe you anti-viral medication to start one day prior to laser treatment.

Female (when was your last menstrual cycle) _____

Signature:_____Date:_____ ___