NOVAS • DOHR • COLL & GADSON MEDICAL SPA
BEAUTY AND WELLNESS

NAME___________________________________ **DOB** ___________**AGE**_______

Are you a medical patient of Novas, Dohr & Coll, OB/Gyn Associates? Yes____ No____

Describe your skin: (check all that apply) thick___ thin___ saggy___ firm___ normal___ dry___ acne scarred
____

large pores___ florid___ rosacea___ eczema___ freckled___ t-zone / combination___ oily___ acne___ milia
cysts____

breakouts___ sallow___ melasma___ perfume stained___ hypo-pigmented___ hyper-pigmented___ psoriasis___

dehydrated___ asphyxiated___ telangiectaia/broken surface capillaries___

Do you consider your skin: sensitive___resilient___not sure___

Eye color: blue___ green___ hazel___ gray___ light brown___ medium brown___ dark brown___

Hair color: blonde___red___light brown___medium brown___dark brown___black___silver/gray___white___

Skin tone: pale/white___light___medium___reddish___freckled___light olive___medium olive___ dark olive___

light brown___medium brown___dark brown___soft black___black___sallow___

What is your hereditary background? ____

Please list all medications you are taking: ____

Are you currently taking any of these medications?

Aspirin___ Advil___ Blood Thinners___ Vitamin E___ Vitamins___ Herbal Supplements___

Allergies: _______________________ **Are you on Antibiotics at this time:** ________________________

Do you have any of the following illnesses or have ever had in the past:

Herpes &/Or Vaginal Herpes___ Myesthenia Gravis___ Hepatitis___ Eye Disease___ Autoimmune Disease___

Vision Problems___ Numbness___ Muscle Weakness___ Multiple Sclerosis___ Amyotrophic Lateral Sclerosis (ALS)_____

Parkinson's Disease___ Neurological Disorders___ Lambert-Eaton Syndrome____ Bleeding Disorders___ Cancer_________

Do you develop cold sores? Yes ____ No ____ Last Breakout? ______________________

Are you Pregnant, Trying to get Pregnant, or Lactating (nursing)? ____

Please List and /or Explain Other Medical Conditions not listed above: ____

____

Please List and Date All Previous Hospitalizations or Operations: ____

____

Have you had any plastic surgery, facial implants, other implants (breast, face, body), liposuction or fat injections?

Yes ___ No ___ When/where __________ What kind ____

Do you wear contact lenses Yes ____ No ____

Do you have permanent makeup? Yes ____ No ____ If so, to what areas of face? __________________

Do you currently have a sunburn/windburn/red face? Yes ____ No ____ Why ______________________

Are you allergic/sensitive to: (check all that apply) milk___ apples___ citrus___ grapes___ aloe vera___ aspirin ___

perfumes___ latex___ hydroquinone___ mushrooms___ other - describe___________________________

Are you sensitive to alcohol-based products? Yes___ No ___ **Do you smoke?** Yes ____ No ____

Had collagen, Restalyne or Juvederm injections before Yes___ No___ Last treatment _______ What area ______________

Are you in the habit of going to tanning booths? Yes ____ No ____ (if within 3 wks decline treatment)

Are you currently using depilatories? Yes ____ No ____ (discontinue use 7 days before and after treatment)

Are you currently using Retin-A/Renova/Differin? Yes ____ No ____ Strength____ For how long? __________

How frequently? __________ Where applied? ________ (Discontinue use 5 days before and after treatment)

Are you currently using Accutane? Yes ____ No ____ how long? __________(Discontinue use 10 days before and after treatment – make sure you consult the prescribing physician before stopping use of any prescription)

Have you ever had a peel? Yes ____ No ____ within the last 14 days? Yes ____ No ____

Have you recently had laser resurfacing? Yes ____ No ____ When ____________What kind? _______________

Have you had laser hair removal? Yes ____No ___ when & how many times ________________

What areas treated? ____

Have you waxed? Yes ____ No ____ How long ago ______________ what areas? __________________________________

Have you ever used any products that caused a bad reaction? Yes___No___ Describe____________________________

What is your daily home care regimen? ____

What are the cosmetic improvements you would like to see in your skin? ____

____

Had Botox® injections before Yes___ No___ Last treatment _____ What Areas ____________________________________

Were you happy with previous Botox® treatments? Yes___ No___

Have you experienced any complications or Botox® resistance? Yes___ No___

Have you ever had eyelid/eyebrow droop after Botox® Yes___ No___

Do your eyelids feel extra heavy when you don't get enough sleep? Yes___ No___

Do your eyelids droop without sleep? Yes___ No___

If you previously had Juvederm, were you happy with results? Yes___ No___

Have you experienced any complications with bruising or lumps at injection site? Yes___ No___

Were your previous injectables given by a physician or nurse? ___________________

Areas of special concern?____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form. I understand this is an elective procedure and I hereby voluntarily consent to treatment [which can include Botox® or Juvederm injection for the condition known as: Facial Dynamic Wrinkles.] The procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure.

Patient Signature __________________________________ **Date** _______________________

Esthetician Signature ________________________________ **Date** _______________________