Pennington Med Spa, LLC
Skin care, Laser & Weight Loss Clinic

~PATIENT INFORMATION~

(PLEASE PRINT)

Last Name _____ First Name _____ Middle Initial _____ ( ) Cell Phone _____

Address _____ ( ) Home Phone _____

City _____ State _____ ZIP _____

Male/Female _____ / / _____

Sex (Circle) Age Birthdate (Mo/Day/Year) Email

Patient Employer _____

Occupation _____

Employer Address _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Emergency Contact's Address _____ Emergency Contact's Phone _____

Primary Care Physician: _____

Primary Care Physician Phone #: _____

Current Medications

Please list any **medications or suppliments** you are taking: _____

Topical Medications: (ie. Hydroquinone, Renova, Retin-A, Defferin, etc.) _____

Personal Health History:

Please list any and all **allergies**: _____

Please list any **immune disorders** or illnesses: _____

Please list any **surgeries**: _____

Are you currently under medical supervision: Yes_____ No_____ Please explain: _____

Please circle if YOU have ever had the following:

Asthma	Breast cancer	Cancer	Diabetes	Chest pain/tightness
Eczema	Use CPAP	Heart Murmur	Hepatitis	High blood pressure
Kidney stones	Stroke	Thyroid disorder	Sleep apnea	Herpes/cold sores

Patient/Client Name: (page 2) _____

Are you **pregnant** or planning to become pregnant? Yes_____ No_____ Breastfeeding_____

Are you currently taking **birth control**? Yes_____ No_____ Regular Periods? Yes_____ No_____

Are you going through **menopause** _____ Have you had a hysterectomy _____ Full_____ Partial_____

Do you **drink alcohol**? Yes _____ No_____ Number of drinks per week _____ Month_____

Do you **smoke**? Yes _____ No_____ Quit _____ Quit when?_____ Number of years smoked_____

Do you drink **caffeine**? Yes_____ No_____ What? # drinks/day?_____

Family Medical History: Please list afflicted family member/immediate family only

Abnormal bleeding/clotting		Kidney disease	
Adopted		Liver disease	
Autoimmune disorders		Obesity	
Brain tumor		Skin cancer	
Diabetes		Other cancer	
Endocrine disease			
heart disease			
high blood pressure			

Acknowledgement of Receipt of Notice of Privacy Practices

Please Note: A copy of our Notice of Privacy Practices (HIPPA) is attached/available for your reading and review. Please read and sign below acknowledging receipt there of.

Please let us know if you would like a paper copy of this notice for your personal files. You may also obtain a copy on our website: PenningtonMedSpa.com

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Pennington Med Spa and Transformation Weight Loss Clinic.

Signature:_____ Date:_____

Weight Loss Patients Only

Weight: Current Heaviest Lowest **Size:** Current Largest/Smallest

Weight loss results vary among patients and are not guaranteed

Have you ever participated in other weight loss programs?_____ Which ones? _____

Have you ever taken appetite suppressants?_____ Which ones?_____ Please list any negative side effects you experienced

_____

What is your ideal weight goal? _____ Clothing size goal?_____ Current Activity Level_____

Have you ever had lipo?_____ When?_____ Tummy Tuck?_____ When?_____

Have you ever had bariatric surgery?_____ When?_____ What type?_____

Client Name (page 3): _____

Skin Care Patients

Please check any condition that applies to you:

_____ Contagious Skin Condition	_____ Varicose Veins	_____ Fibromyalgia
_____ Circulatory Disorder	_____ Phlebitis	_____ TMJ
_____ Open Sores or Wounds	_____ Deep Vein Thrombosis/Blood Clots	_____ Decreased Sensation
_____ Bruises Easily	_____ Joint Disorder/Arthritis/Osteoarthritis	_____ Carpal Tunnel
_____ Recent Accident or injury	_____ Epilepsy	_____ High or low BP
_____ Recent Fracture or Surgery	_____ Headaches/Migraines	_____ Heart condition
_____ Artificial Joints	_____ Current Fever	_____ _____
_____ Sprains/Strains	_____ Swollen Glands	_____ _____

What is your daily skincare routine?

Daytime:_____

Evening: _____

Skin History

How would you describe your skin? Dry_____ Oily_____ Combination_____ Mature_____ Sun-damaged_____

Acne Grades 1&2 ___ Acne Grades 3&4____ Rosacea/Broken Capillaries___ Large Pore Size___

Scarring and/or Acne Scarring _____ Discoloration_____ Uneven Skin Tone_____

Females: Do you suffer from hormonal hair growth on upper lip, chin, and/or chest? Yes_____ No_____

How often are you in the sun? Frequently_____ Occasionally_____ Rarely_____

Have you or any member of you family has skin cancer? Yes_____ No_____

How often do you use sunscreen? Frequently_____ Occasionally_____ Rarely_____

What is you skin tone? Very Fair_____ Fair _____ Medium_____ Medium- Olive_____ Dark_____ Very Dark_____

Do you prefer extraction when you have a professional facial treatment? Yes___ No___

How often do you receive facials, chemical peels, microdermabrasion, cosmetic laser treatments, and cosmetic injections:

_____

_____ _____

Patient/Client Signature Date

_____ _____

Intake Provider's Signature Date