INTERLOCKS ™
MEDSPA + WELLNESS

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____

City : _____ State: _____ Zip Code: _____

Home Phone: _____ Okay to leave confidential message? Y / N

Cell Phone: _____ Okay to leave confidential message? Y / N

E-Mail: _____

Emergency Contact *Name:* _____ *Phone #:* _____

How were you referred? _____

Primary Care Physician Information:

Name/Office: _____

Street Address: _____

City : _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Pharmacy Name: _____ Pharmacy Phone: _____

MEDICAL HISTORY

Are you currently under the care of a physician? Y / N

If yes, please explain: _____

Are you currently under the care of a dermatologist? Y / N

If yes, please explain: _____

Please answer YES or NO to the below medical history questions:

	Y	N	N/A
Have you ever been treated with Botox® or other neurotoxin?			
Have you ever been treated with any fillers?			
Do you have any facial implants?			
Do you have any skin sensitivity?			
Have you had significant sun exposure in the last 4 to 6 weeks?			
Do you have tattoos or permanent makeup in areas to be treated?			
Do you ever have cold sores or fever blisters?			
Are you currently pregnant or trying to conceive?			
Are you currently breastfeeding?			
Are you using a contraceptive?			
Do you have implants?			
Have you had surgery performed in the last 6 months?			
Have you had any dental work performed in the last 2 weeks, or planning in the next 2 weeks?			

INJECTABLES

Do you have any of the following medical conditions? Please check all that apply.

☐ Cancer	☐ Gold Therapy	☐ Seizure Disorder	☐ Vitiligo
☐ Any Active Infection	☐ Frequent Cold Sores	☐ Hormone Imbalance	☐ HIV/AIDS
☐ High Blood Pressure	☐ Keloid Scarring	☐ Thyroid Imbalance	☐ Herpes
☐ Arthritis	☐ Coagulopathies	☐ Pacemaker/Defibrillator	☐ Diabetes
☐ History of Melanoma	☐ Skin Disease/Skin Lesions	☐ Bleeding Abnormalities	☐ Hepatitis
☐ Myasthenia Gravis	☐ Allergy to Botulinum Toxin	☐ Blood Disorders	☐ Depression
☐ Burns or Skin Grafts	☐ Steroid/Hormone Therapy	☐ Lambert Eaton Syndrome	☐ Anxiety
☐ Swallowing Problems	☐ Alcoholism	☐ Kidney Disease	☐ Shingles
☐ Skin Pigmentation	☐ Muscle Weakness	☐ Lou Gehrig's Disease	☐ Drug Abuse

Do you have any other health problems or chronic medical conditions? Please list: _____

_____

ALLERGIES

Have you ever had an allergic reaction to any of the following medications? Please check all that apply and describe the reaction you experienced.

☐	Food	
☐	Latex	
☐	Asprin	
☐	Lidocaine	
☐	Hydrocortisone	
☐	Hydroquinone/skin bleaching agents	
☐	Other	

Do you have any other known allergies? Please list: _____

_____

MEDICATIONS

What oral medications are you presently taking? Please include Aspirin, Ibuprophen, Advil, hormones and/or birth control if applicable. _____

_____

Are you on mood altering or anti-depressant medication? Y / N

Have you ever used Accutane? Y / N If yes, when did you last use it? _____

How much alcohol to you dink: Daily? _____ Weekly? _____

What herbal supplements do you use regularly? _____

_____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor or nurse injector of my current medical or health conditions and to update my history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature:_____ Date: _____