

JÄNNHA MEDISPA REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's Last name: _____ First: _____ Mr. Miss Mrs. Ms. Marital status (circle one)
Single / Mar / Div / Sep / Wid

Birth date: ____ / ____ / ____ Age: _____ Sex: M F

Street address: _____ Email: _____

Home phone no.: () _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____ Employer phone no.: () _____

Chose clinic because/Referred to clinic by (please check one box): Dr. Insurance Plan Hospital
 Family Friend Close to home/work Yellow Pages Other

Referred By: _____

Other family members seen here: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: () _____ Work phone no.: () _____

Have you ever had or been diagnosed with any of the following?

	Yes	No		Yes	No		Yes	No
Heart Murmur	()	()	Circulatory problems	()	()	Phlebitis	()	()
Blepharoplasty	()	()	Do you wear contacts	()	()	Skin cancer	()	()
Fainting/Dizzy spells	()	()	Hyper-pigmentation	()	()	Allergies	()	()
Keloids	()	()	High blood pressure	()	()	Diabetes	()	()
Thyroid disease	()	()	Bleeding disorder	()	()	Hepatitis	()	()
Herpes Simplex	()	()	Chemotherapy/radiation	()	()	Asthma	()	()
Tumors/Growths	()	()	Corneal abrasions	()	()	Do you smoke	()	()

List all medications you are currently taking:

List any drug, makeup, food, or skin allergies:

Previous Cosmetic Treatments:

	Yes	No		Yes	No
Acid Peel	()	()	Face Lift	()	()
Laser Surgery	()	()	Botox	()	()
Collagen	()	()	Microdermabrasion	()	()

Skin type: Oily Normal Dry Sensitive Combination
Skin Condition: Rough Texture Sun damage Acne Uneven color/pigmentation Large pores
Areas of concern: Oily/acne Aging Dry skin Uneven tone Maintenance/prevention

	Yes	No
Have you been on Accutane in the past nine months?	()	()
Laser resurfacing in the past year?	()	()
Are you using, or have ever used Retin-A? When was your last application? _____	()	()
Are you pregnant? If so, how far along are you? _____	()	()
Have you ever been tested for HIV? If so, results? _____	()	()
Do you have an immune disorder that would impair your healing process?	()	()
Are you prone to general herpes breakouts? Cold sores?	()	()
Do you have any venereal diseases? If so, what are they? _____	()	()
What is your natural hair color? _____		
What is your natural eye color? _____		
Have you recently undergone a skin peel? If so, how long ago? _____	()	()
Is your skin condition normal or abnormal? _____		
When did you last tan your skin? _____		
When were you last exposed to sun, tanning beds, creams? _____		
Have you ever had sclerotherapy? If so how long ago? _____	()	()
When a scar appears on your skin, is it significantly dark in color?	()	()
Are you currently taking any birth control pills?	()	()
Are you taking oral or injectable steroids?	()	()
In your own words, describe your skin: _____		
What about your skin are you hoping to improve? _____		
Going back three generations what is your family ancestry? _____		

Fitzpatrick Skin Test (Please circle the one that describes your skin type.)

Type I: always burns, never tans. Read her blonde hair, light eyes.

Type II: somewhat tans, mostly burns.

Type III: sometimes burns, mostly tans, also known as olive complexion.

Type IV: rarely burns, almost always tans, also known as olive complexion.

Type V: moderately pigmented (Indian, Persian, light African-American)

Type VI: African-American

Skin care regimen (specify products are currently using):

Cleanser _____

Exfoliant _____

Treatment _____

Hydration _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jännha MediSpa at Medical Art Center or my insurance company to release any information required to process my claims.

Patient/Guardian Signature

Date