Today's date: ___________________________

Patient: ____ Birthdate: ______________

Email: ____

Address: ____ Zip: ___________________

Primary Phone: ________________________________ Preferred way to be contacted ☐ Phone ☐ Email ☐ Text

Fitzpatrick Skin Type

☐ I – Always burn, never tan ☐ III – Sometimes burns, always tan ☐ IV – Rarely burns, always tans

☐ II – Always burns, sometimes tan ☐ V – Brown, moderately pigmented skin ☐ VI – Black skin

History of Cosmetic/Aesthetic Procedures

Have you ever had any facial surgery performed? ☐ No ☐ Yes Type: ____________________________

Have you ever had any of the following injectable procedure done? *(Check all that apply)*

☐ Botox ☐ Juvéderm ☐ Restylane ☐ Radiesse ☐ Collagen ☐ Sculptra Other: ____________

Have you ever had a chemical peel? ☐ No ☐ Yes Type: ____

Have you ever had any type of laser treatment? ☐ No ☐ Yes Type: ___________________________________

Have you had any *recent* tanning bed or sun exposure that changed the color of your skin? ☐No ☐Yes

Have you *recently* used any self-tanning lotions or spray tan treatments? ☐ No ☐ Yes Type: ________________

Have you had any cosmetic tattoos? ☐ No ☐ Yes If yes, where: _______________________________________

Areas of Concern *Check all that apply*

☐ Tummy Appearance	☐ Forehead Lines	☐ Smile Lines
☐ Muscle Tone	☐ Heavy/drooping Eye Lids/brow	☐ Sun Damage
☐ Acne/Pimples	☐ Hyperpigmentation	☐ Sunken corners of lips
☐ Age Spots/Sun Spots	☐ Lines Around Lips	☐ Stretch Marks
☐ Clogged Pores	☐ Lines Between Eyes	☐ Tattoo Removal
☐ Crow's Feet	☐ Lip Volume	☐ Thinning Eyelashes
☐ Cellulite	☐ Lower Back "Muffin Top"	☐ Thinning Hair/Hair Loss
☐ Dryness/Dry Patches	☐ Melasma	☐ Uneven Skin Tone
☐ Enlarged Pores	☐ Neck Lines	☐ Varicose/Spider Veins
☐ Excessive Facial/Body Hair	☐ Redness/Rosacea	☐ Visible Facial Veins
☐ Excessive Oiliness	☐ Scarring	☐ **Other** _______________
☐ Facial Lines/Wrinkles	☐ Skin Laxity/Sagginess	

Have you ever used Accutane? ☐No ☐ Yes - If yes, when did you last use it? ___________________________

What is your current Skincare Regimen (Face wash, scrub, serum, moisturizer, SPF, etc)? List any topical Medications.

____

____

____

Medication Allergies ☐ No Known Drug allergies

Medication	Reaction	Medication	Reaction

Medications *(please list ALL current medication including vitamins/supplements)*

Medication	Dose	Frequency	Medication	Dose	Frequency

Surgery history

Medical History *Check all that apply*

- ☐ Acne
- ☐ Any Active Infections
- ☐ Arthritis
- ☐ Auto Immune Disease
- ☐ Bleeding Disorders
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cold Sores
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Hearing
- ☐ Gold Therapy
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormone Imbalance
- ☐ **No health problems**
- ☐ Pain in Legs
- ☐ Peripheral Vascular Disease
- ☐ Rosacea
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Skin Disease/Skin Lesions
- ☐ Slow Healing
- ☐ Thyroid Imbalance

Do you have any other health problems or medical conditions (not listed) that may help us in your treatment plan? Please list: ____

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 Aesthetician, Nurse, PA or Doctor of my current medical or health conditions and to update this history. A current medical history is essential for VIVAA to execute appropriate treatment.

Signature: ____Date: ______________________

Name (Please print clearly): ____