REJUVENATION SPA OF ALPHARETTA

Christi Stowers Enterprises | 1380 Upper Hembree Road, Roswell, GA 30076

General Health Information

NAME ____________________ DATE ____________________

ADDRESS ____________________ CITY & ZIP ____________________

HOME ____________________ CELL ____________________ WORK ____________________

E-MAIL ____________________ DATE OF BIRTH ____________________

Have you had these conditions? (Check if yes)

_____________ AIDS
_____________ Anemia
_____________ Arthritis
_____________ Auto Immune Deficiency
_____________ Asthma
_____________ Blood Disease
_____________ Blood Transfusion
_____________ Chemotherapy (active)
_____________ Diabetes
_____________ Dizziness
_____________ Epilepsy
_____________ Fainting
_____________ Hay Fever
_____________ Heart Disease
_____________ Hepatitis
_____________ High Blood Pressure
_____________ Infection (active)
_____________ Kidney Disease
_____________ Liver Disease
_____________ Lupus
_____________ Melanoma
_____________ Mental Disorder
_____________ Nervous Disorder
_____________ Radiation Treatment
_____________ Respiratory Problems
_____________ Skin Conditions
_____________ Sinus Problems
_____________ Stomach Problems
_____________ Stroke
_____________ Thyroid Problems
_____________ Tuberculosis
_____________ Ulcers
_____________ Venereal Disease

Are you ALLERGIC TO ANY MEDICATIONS (RX/or OTC)?

Medication Allergy: ____________________

Cosmetic Allergy: ____________________

Latex/Other Allergy: ____________________

Have you ever/are you currently using:

Retin-A, Renova, any retinoic product	YES	NO
Accutane	YES	NO
Prescription Acne Medication	YES	NO
Birth Control Pills / Patch	YES	NO
Steroids	YES	NO
Are You Pregnant? Due __________	YES	NO
Are You Lactating?	YES	NO

Previous Cosmetic Facial Treatments

Acid Peel	YES	NO	DATE: ____________
Botox	YES	NO	DATE: ____________
Restylane	YES	NO	DATE: ____________
Dermal Fillers	YES	NO	DATE: ____________
Collagen	YES	NO	DATE: ____________
Tattoo/Perm Makeup	YES	NO	DATE: ____________
Waxing	YES	NO	DATE: ____________
Facial Surgery	YES	NO	DATE: ____________
Laser Surgery	YES	NO	DATE: ____________
Microdermabrasion	YES	NO	DATE: ____________
IPL/Laser Hair	YES	NO	DATE: ____________

Have You Ever Had?

Cold Sore / Fever Blister YES NO

Frequency: <1 Year 1-3/year 4+/year

List all current medications/supplements that you take:

____
____
____
____
____

Patient/Guardian Signature:____________________ Date:____________________