ARCTIC MEDICAL CENTER MATSU

Aesthetics Consultation Form

Date:_____

Name: _____ DOB: _____ Sex: M / F

Phone - Home :(___)_____Cell: (_____)_____

Address_____

City_____State_____Zip_____

E-mail _____(Please print clearly to receive promotions)

How did you hear about Arctic Medical Center Matsu?_____

Please mark the concern(s) that brought you in today:

___Brown Spots / Age Spots
___Facial Redness
___Pore size
___Collagen Augmentation
___Wrinkles and Sun Damage
___ Cellulite Reduction
___ Lines around nose/mouth
___ Rough/tired looking

Medical History: Please check all that apply (past and the present)

___Waxing/Plucking/Electrolysis within the last 2 weeks.
___Pregnant
___Bleeding Abnormalities
___Treatment with Accutane in the last 6 months.
___Keloid or very thick scarring
___Psoriasis or Vitiligo
___Leg ulcer or Phlebitis
___Blood thinning medication
___Rheumatoid Arthritis "Gold" Therapy
___Herpes simplex or fever blisters
___Lupus or other auto-immune deficiency
___Diabetes
___Epilepsy
___Scars that turn white or brown
___Dark spots after pregnancy, skin injury
___HIV or Hepatitis
___Pacemaker/Heart Defibrillator
___Hirsutism
___Transplant Anti-rejection drugs
___Chemical peels, dermabrasion, laser resurfacing or facelift
___ History of MRSA

Please list any medications or herbal supplements that you are currently taking including topicals:

_____
_____
_____
_____

Allergies: _____

Are you currently under doctor's care for any medical conditions? ____ yes ____ no

Signature of Patient: _____ Date: _____