FINESSE
ADVANCED MEDICAL AESTHETICS

Please answer the following questions so your clinician can have a better understanding of your general health, lifestyle, skin conditions and concerns

Name:____Date of Birth_________________

Address:____City:______________State:_______Zip:__________

Home Phone:__________________ Mobile Phone:__________________ Preferred Number Home / Mobile

Email :____ Can we email? Y / N Can we text? Y / N

Emergency contact name _____________________________________ Emergency contact number________________

Medical History:

Employer______________________________Profession_____________________________________

Are you under the care of a Physician? Yes or No

If so, for what?____

Are you taking any oral medications Yes or No

If so, please list____

Do you have a current of chronic illness? Yes or No

If so, please list____

Do you have any known allergies? Yes or No

If so, please list all known allergies____

Do you have or have you had Herpes Simplex (or Cold Sores) Yes or No

Do you have epilepsy? Yes or No

Do you have any autoimmune disorders (ex: Thyroid, Rheumatoid, Lupus) Yes or No

Do you have any metal implants, heart issues or pacemakers? Yes or No

Have you been on Accutane? Yes or No

Female Clients Only:

Are you currently pregnant? Yes or No

Are you currently breast feeding? Yes or No

Have you gone through menopause? Yes or No

Signature____ Date__________________