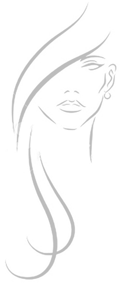

APTOS MEDICAL AESTHETICS

Mary Codiga, RN / John Crowder, MD

CLIENT INTAKE FORM

Name: ____ Date: ________________________

Email: ____

Address: ____

____, __________, __________________
(city) (state) (zip)

Telephone: ____________________________ (home) _________________________________ (cell)

Date of Birth: ____________________________ Employer: ____________________________________

Emergency Contact: ___________________________________ Telephone: _______________________

How did you hear about Aptos Medical Aesthetics? ____

Medications: (please list any medications or supplements (e.g. aspirin, herbals, fish oil, etc.)

____

Allergies: (please list any medication allergies)

____

Are you allergic to Latex? ___ (yes) ___ (no)
Are you allergic to Lidocaine? ___ (yes) ___ (no)
Are you current nursing: ___ (yes) ___ (no)

Are you currently pregnant, or
planning on becoming pregnant? ___ (yes) ___ (no)

Please check ALL that apply:

___ Polycystic Ovaries
___ Anemia
___ Asthma
___ Autoimmune Disease
___ Fibromyalgia
___ Hepatitis A, B, C
___ Herpes/Cold Sores
___ Bleeding Disorder
___ HIV/Aids
___ Cancer
___ Connective Tissue Disorder
___ Epilepsy
___ Migraines
___ Neuromuscular Disorder
___ Pacemaker/Defibrillator
___ Diabetes
___ History of Keloid Scarring
___ Skin Lesion
___ Pigmentation Disorder
___ Seizures