Jeunesse MedSpa® Patient Registration

Date: _____

Mrs. / Ms. / Miss / Mr. / Dr. (please circle)

Name: _____

Address: _____

DOB: _____ ***Ethnicity:** _____

Mobile: _____ **Alternative Contact No:** _____

Email: _____

***Occupation:** _____

How did you hear about us?

Friend/Family Beauty Therapist GP Our Website Yellow Pages Book Yellow Pages Online

Facebook Newspaper Magazine Internet Search Other

Who do we thank(Name) _____

Medical History

GP: _____

Medical Conditions: _____

Surgical History: _____

Medications (Natural or Conventional): _____

Known Allergies: _____

*****Smoking History: Smoker / Non - Smoker / Ex - Smoker

****Smoking History, Ethnicity and Occupation are particularly important as they can affect treatment outcomes***

Areas of Concern (Please Circle)

Facial Lines:	Frown Lines / Crows Feet / Brow Line / Smile Lines
Pigmentation:	Face / Neck / Chest / Hands
Lips:	Shape / Size / Lines
Skin lesions:	Skin Tags / Skin Cancer / Solar Keratosis
Acne:	Face/ Body / Scarring
Skin Condition:	Milia / Rosacea / Facial Veins
Hair Removal:	Face / Arms / Legs / Body
Excessive Sweating:	Underarms / Hands / Feet
Ageing:	Neck / Hands
Sexual Function:	Incontinence/ Improving Sexual Potential/ Erectile Dysfunction

Do you wear sunscreen every day?	Yes / No
Are you happy with your skin care regime?	Yes / No
Have you had any previous cosmetic procedure?	Yes / No

Please provide details:

- *Would you like to receive email updates on the latest treatments and specials available at Jeunesse?* **Yes / No**
- *Would you like to join our birthday club?* **Yes / No**

ALL INFORMATION CONTAINED ON THIS FORM WILL BE HELD IN THE STRICTEST CONFIDENCE

Thank you for choosing Jeunesse MedSpa® as your Appearance Medicine Clinic