Center For Aesthetic Surgery

Medical Spa Consultation Form

Name:_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Top three skin concerns at this time?

1._____2._____3._____

Medical History

Pregnant: Y N Maybe Breastfeeding: Y N Smoke: Y N

Current Medications:_____

Current Topical Prescriptions:_____

Allergies:_____

Previous Treatments:

Facials: YES /NO Date:_____ Any Complications?_____

Dermaplaning: YES /NO Date:_____ Any Complications?_____

Microdermabrasion: YES /NO Date:_____ Any Complications?_____

Chemical Peel: YES/ NO Date:_____ Any Complications?_____

Waxing: YES/ NO Date:_____ Any Complications?_____

Microneedling: YES/ NO Date:_____ Any Complications?_____

Laser Treatments: YES/ NO Date:_____ Any Complications?_____

Botox: YES/ NO Date:_____ Any Complications?_____

Fillers: YES/ NO Date:_____ Any Complications?_____

What is your current skincare regimen?

Skin: DRY OILY COMBINATION NORMAL SENSITIVE

Products: *Please indicate any cleansers, toners, serums, masks, moisturizers and/or spf.*

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