FABULOUS FACES AESTHETIC & LASER CENTER
302.827.2125
34172 CITIZENS DRIVE • LEWES • DELAWARE • 19958

TODAY'S DATE: ___________________

CLIENT INFORMATION

LAST NAME: ____FIRST NAME: _____________________________ DOB: ________________

STREET ADDRESS: ____

CITY, STATE & ZIP CODE: ____

HOME PHONE: ____ CELL PHONE: ____

OCCUPATION: ____ EMAIL: ____

WOULD YOU LIKE TO RECEIVE SPECIAL OFFERS AND PROMOTIONS VIA EMAIL? ☐ YES ☐ NO

EMERGENCY CONTACT: _____________________________ PHONE: __________________________ RELATION: _____________________

PLEASE CHECK ANY HEALTH CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

☐ CANCER	☐ HIV OR OTHER IMMUNE DEFICIENCY DISORDER
☐ DIABETES	☐ LIVER DISEASE
☐ EPILEPSY	☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE	☐ ANXIETY DISORDER
☐ HEART PROBLEMS	☐ HORMONE IMBALANCE
☐ TUBERCULOSIS	☐ HERPES OR COLD SORE
☐ HEPATITIS	☐ WARTS, DERMATITIS, PSORIASIS, ECZEMA, IMPETIGO, OR MRSA, ROSACEA, OR ANY OTHER SKIN DISORDER

PLEASE LIST ALL **MEDICATIONS**, PRESCRIPTION AND NON-PRESCRIPTION YOU ARE CURRENTLY TAKING:
____
____
____
____

PLEASE LIST ALL **ALLERGIES**:
____
____

PLEASE CHECK ALL THAT YOU ARE CURRENTLY USING OR HAVE USED IN THE PAST:

☐ ORAL CONTRACEPTION	☐ BENZOYL PEROXIDE
☐ DAILY ASPIRIN THERAPY	☐ SALICYLIC ACID
☐ ANTI-COAGULANT MEDICATION	☐ GLYCOLIC ACID
☐ TRETINOIN, RETIN-A, REFISSA, RENOVA, DIFFEREN GEL	☐ ACCUTANE OR ISOTRETINOIN

ARE YOU **PREGNANT OR LACTATING**? YES NO
ARE YOU CURRENTLY TAKING OR HAVE TAKEN **ANTI-BIOTICS** IN THE PAST TEN DAYS? YES NO

How did you hear about us? _________________________Referred by:____
What other services do you have an interest in? Please check any or all that apply:
_____ Botox/Fillers _____ Cosmetic Surgery _____ Permanent Makeup _____ Laser Services _____ Teeth Whitening

I CONFIRM THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND THAT I HAVE NOT WITHHELD ANY INFORMATION THAT MAY BE RELEVANT TO MY TREATMENT.

SIGNATURE: ____ DATE: ______________