

- All information will remain confidential

Personal Information:

Last Name: _____ First Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Birthday (Mo./Day/Yr): _____
 How did you hear about us? _____
 Email Address: _____

Medical History-

Please check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Blood Clotting disorders | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Breast Feeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sports Injuries |

1. Are there any medical conditions we need to know about?

2. Are you currently using any of the following?

- | | | | |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Retin-A |
| <input type="checkbox"/> Acne Drugs | <input type="checkbox"/> Bleaching Agents | <input type="checkbox"/> Hormones | <input type="checkbox"/> Natural remedies |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Blood thinners (Plavix/Coumadin) | <input type="checkbox"/> Hydro-Cortisone Creams | |
| <input type="checkbox"/> Vitamin E | | | |

3. Are there any other medications that you are on?

4. Have you ever had a reaction to any of the following?

- | | | | | | |
|-------------------------------------|------------------------------------|------------------------------------|---------------------------------|------------------------------------|--------------------------|
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Food | <input type="checkbox"/> Medicines | <input type="checkbox"/> Iodine | <input type="checkbox"/> Cosmetics | <input type="checkbox"/> |
| Fragrance | | | | | |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Sunscreen | | | | |

5. If other, please describe:

I understand and adhere to Turquoise Spa's 24-hour cancellation policy.

Client's Signature

Date