CARY MED
SPA & WELLNESS
Total Care for Your Body

MEDICAL HISTORY

Name ________________________________ Client ID#: ______________

Birthdate (mm/dd/yy): ______________________ Referred by: ______________________

Address ______________________________ City: ______________________

Province: __________ Postal Code: __________ Country: ______________ American Citizen: Y ☐ N ☐

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Can leave a message at: Home ☐ Work ☐ Cell ☐ Email ☐

Email Address: ____

Emergency Contact Name and Number: ______________________________

Age __________ Height __________ Weight __________ Occupation ______________________

How did you hear about us? (Circle all that apply)
Newspaper / Television / Radio /Google / Website / Facebook / Friend: ______________________

There exists a risk if our staff is not aware of the general health and medical background of a client. This information may critically affect what procedure we may recommend or safely undertake. Please provide us with the following information and keep it updated.

Please circle all of the following medical conditions you now have or have had in the past, if you have had none, please circle "None of the above"

bleeding tendency / diabetes / Hormonal Imbalance/ Hyperthyroidism/ Hypothyroidism/ blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / high blood pressure / pace maker / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / rheumatoid arthritis / scleroderma / lupus / porphyria / depression / mental illness / drug or alcohol addiction / hepatitis B / hepatitis C / HIV / contact lenses / loose or chipped teeth / dentures / dental implants / veneers / caps **None of the above** / **any other serious illness or injury please explain**:

____

Please list all medications that you are currently taking or have used in the past 6 months. **Use the back of page if necessary.**

Medication(s)	Amount	Frequency

Please list all Naturopathic, Health Food Supplements and Vitamins:

Please list all **ALLERGIES** including **LATEX**: ________________________________

____

Client ID#: ____________________

Are you a smoker? Yes ☐ No ☐ If you are an ex-smoker, for how long are you smoke free? ____________________

How much are (were) you smoking? ______________________________ For how long?: ____________________

How On a daily basis how much of the following liquids do you drink?

Alcohol ________ Coffee ________ Tea ________ Water ________ Soda ________ Juice ________ Other ________

(Yes / No) Do you have a history of cold sores? If yes, when was your last outbreak? ____________________

Do you or your family have a history of atypical moles, vitiligo, developing keloids, melanoma or skin cancer?

If yes, please circle which and explain: ____

Please list all surgeries that you have had (include plastic surgery and wisdom teeth removal) with the date you had the surgery:

____

____

____

Have you or anyone in your family ever had or have a history of unusual reactions or problems with **LOCAL** anesthesia (dental freezing), **TOPICAL** anesthesia (anesthetic creams or gels) or **GENERAL** anesthesia (rashes, muscle weakness, jaundice, breathing problems or unexpected fevers(s))? Yes ☐ No ☐

If yes, please explain: ____

Have you ever seen a cardiologist? Yes ☐ No ☐ Physician Name: ______________________________

Date of last EKG?

Payment Type: We accept cash, check, credit or debit cards, and Care Credit for payment of services. We do not accept insurance.

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. I, ______________________________, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.

If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential unless otherwise disclosed.

I understand that there is a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE: ______________________________ DATE: ____________________

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

CARY MED
SPA & WELLNESS
Total Care for Your Body

Client Care Plan

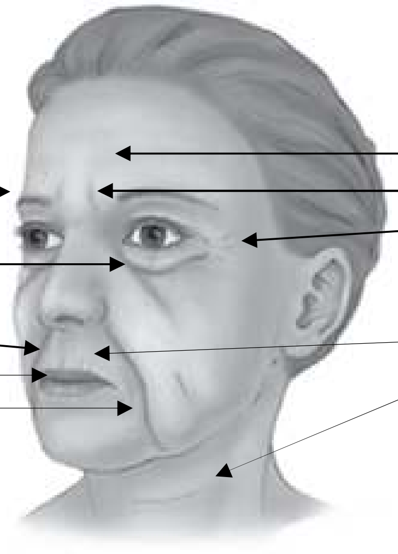
Last Name: ______________________ **First Name:** ______________________

Date: ______________________

Your Aesthetic & Skin Concerns:

Please review the list below and CHECK off the areas you have concerns and/or questions about.

☐ Brown Spots
☐ Redness
☐ Skin Laxity
☐ Texture
☐ Scarring
☐ Dark Circles
☐ Pores
☐ Veins
☐ Firmness
☐ Body Contouring
☐ Acne
☐ Unwanted Hair
☐ Eyelashs



FILLERS

☐ BROW
☐ HALLOWS
☐ SMILE LINES
☐ LIPS
☐ MARIONETTE LINES

BOTOX®

WORRY LINES ☐
FROWN LINES ☐
CROW'S FEET ☐
SMOKER'S LINES ☐
NECK LINES ☐

LAXITY

☐ JOWLS
☐ NECK
☐ CHEEKS

Please feel free to elaborate

☐ Frown Lines Between Brows: ______________________
☐ Horizontal Forehead Lines: ______________________
☐ Crow's Feet / Bunny Lines: ______________________
☐ Opening Up Eyes / Brow Shaping: ______________________
☐ Vertical Lip Line Softening: ______________________
☐ Soften Dimpling Chin / Chin ______________________
☐ Crease: Horizontal Neck Lines: ______________________
☐ Vertical Neck Bands: ______________________
☐ Square Jaw / Jaw Line Softening: ______________________
☐ Upper Nose Wrinkles: ______________________
☐ Soften Down Turned Mouth: ______________________
☐ Gentle Brow Lift: ______________________
☐ OTHER: ______________________

Note Areas Discussed With Client:

____

____

____

MEDICAL HISTORY - UPDATES

Client ID#: ____________________

Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________
Date: ____________ Client Initials: ____________ Date: ____________ Client Initials: ____________