Synergy Wellness and MediSpa, PC
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Lisa Golding-Granado, MD **Danielle D'Alessio, PA-C**

New Client History

Date: _____ **DOB**: _____ [ ] Male [ ] Female [ ] Other

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Cell Phone: _____ Home Phone: _____

Email [print carefully]: _____ Occupation: _____

How did you hear about us? _____

If you were referred, **WHO** referred you? _____

ETHNIC Background (needed for skin typing): _____

MEDICAL HISTORY:

Do you have any **CHRONIC MEDICAL CONDITIONS**/medical history? [ ] yes [ ] no

If so, please list:

_____

Do you have any **ALLERGIES**? [ ] yes [ ] no

If so, please list allergies:

_____

Do you presently take prescription or over-the-counter **MEDICATIONS** / **SUPPLEMENTS**? [ ] yes [ ] no

If so, please list:

_____

Have you ever had any **SURGICAL PROCEDURES** in the past? [ ] yes [ ] no

If so, please list procedures and dates: _____

Have you taken **ACCUTANE** within the past year? [ ] yes [ ] no

Are you on any **ANTICOAGULANTS, ASPIRIN, IBUPROFEN, ALEVE, MOTRIN, OR ADVIL**? [ ] yes [ ] no

If so, please list:

_____

Are you a **SMOKER**? [ ] yes [ ] no

If you stopped, when did you quit? _____

Do you have a history of **COLD SORES, FEVER BLISTERS, OR HERPES I OR II**? [ ] yes [ ] no

If so, when was your last outbreak? _____
(**the use of lasers, IPL, chemical peels, or injectables can trigger an outbreak**)

SKIN CARE

Are you interested in a free Skin Analysis ? [ ] yes [ ] no

FOR WOMEN ONLY:

Are you or could you be pregnant? [ ] yes [ ] no

Are you currently breast-feeding? [ ] yes [ ] no

Is your menstrual cycle normal? [ ] yes [ ] no
If yes, date of last menstrual period: _____ or Menopause ? _____

Are you currently trying to get pregnant? [ ] yes [ ] no

Are you currently under the care of a fertility specialist? [ ] yes [ ] no

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WELLNESS HISTORY:

Have you noticed symptoms such as: (check all that applies)
[ ] Dry hair [ ] Dry Skin [ ] Hair loss [ ] Fatigue

[ ] Decreased muscular strength and tone [ ] Unwanted weight gain

Have you ever been diagnosed with cancer? [ ] yes [ ] no
If yes, what type and when?
_____

Do you have stubborn fat that you just can't get rid of no matter how much you exercise or eat well?
[ ] yes [ ] no
If yes, please list which areas:
_____

Do you have lines around your eyes or on your face that makes you look tired or older than you really are?
[ ] yes [ ] no

COOLSCULPTING
Are you interested in a free CoolSculpting consultation? [ ] yes [ ] no

Social Media Image Posting Permission

This signature is to acknowledge that you are aware that your photos and videos may be used by Synergy Wellness and MediSpa for social media promotional purposes; your identity will be obscured. Also please feel free to share your amazing results and tag us!

Patient Signature: _____ **Date:** _____

COVID CONSENT

Here at Synergy Wellness and Medispa we are following all CDC regulations along with voluntary increased in house precautions. We ask that all patients must respect social distancing, wear a mask, and have their temperature taken before admittance into the office. Please know all examination rooms, reception areas, door handles, and any other publicly used surfaces are disinfected before and after each patient. Although we are actively sanitizing throughout the day, we cannot guarantee your safety from COVID-19 or any other airborne illness. By signing below you have consented to receiving treatment in the office of Synergy Wellness and Medispa.

Patient Name : _____ **Date:** _____

Client Signature: _____