Today's date: ________________
Name: ____
Address ____
City ______________________________ State_____________ Zip _____________
Preferred Contact Number: ☐ Home ☐ Work ☐ Cell
Phone Number:___________________________
May we leave a detailed message at this number? ☐Yes ☐ No
Email Address: ____

Personal Information
Date of Birth: ______________________________ Age_________ Gender: ☐ Female ☐ Male
Marital Status_______________________________ Occupation ______________________________

What Services Do You Want To Learn About?
_____Minimize Wrinkles & Skin Rejuvenation Lines
_____Longer Natural Eye Lashes
_____Facial Redness
_____Age Spots / Melasma / Pigmentation Over All Skin Care
_____Medical weight Loss
_____Laser Hair Removal
_____Tattoo Removal
_____Minimize Acne or Break-Outs Acne Scars
_____Relief Fatigue and increase concertation

How Did You Find Us? (Mark all that apply)
_____Internet
_____Facebook
_____Living Social / Groupon PrideGuide
_____Radio
_____Television
_____Walking By
_____A Friend Told Me –

Previous Cosmetic or invasive or non-invoices fat removal or weight loss Treatments:
Botox ® Date: __________,
Dysport Date: __________,
Dermal Fillers: Date: __________,
Cosmetic Surgery: Date: __________
Chemical Peel: Date: __________,
Microdermabrasion Date: __________
Laser Treatments: Date: __________.
PRP Microneedling (Vampire Facial): Date___________
PRP Facelift (Vampire Facelift): Date: ___________

Medical HISTORY (*please circle all that apply*)

Royal MEDICAL HEALTH

Do you have a history of **herpes** I or II in the area to be treated? Yes No
Cryoglobulinemia or paroxysmal cold hemoglobinuria? Yes No
Have you taken **Accutane** or anticoagulants in the last 6 months? Yes No
Have you taken **Anticoagulants** in the last 6 months? Yes No
(For women) Are you or could you be **Pregnant** or **Nursing** mother (Breastfeeding)? Yes No
Have you had any unprotected **sun exposure** in the last 4-6 weeks? Yes No
Have you used **tanning** creams or tanning beds in the last 4-6 weeks? Yes No
Have you **plugged** your hair or wax in the past 2 weeks? Yes No
Any history of **Folliculitis**? Yes No
Known sensitivity to cold such as **cold urticaria** or **Raynaud's disease**? Yes No
Impaired **peripheral circulation** in the area to be treated Yes / No
Impaired skin sensation? Yes No
Open or **infected** wounds? Y es No
Recent **surgery** or scar tissue in the area to be treated? Yes No
A hernia or history of **hernia** in the area to be treated? Yes No
Skin conditions such as **eczema**, **dermatitis**, or **rashes**? Yes No
Any active implanted devices such as **pacemakers** and **defibrillators**? Yes No
Have you had **darkening** of the skin or **lightening** of the skin? Yes No
Do you have a history of **keloid** or **hypertrophic** scarring? Yes No
Do you have a history of **inflammatory** dermatoses? Yes No
Do you have a history of **Melasma**? Yes No
Do you have a history of **scleroderma**? Yes No
Do you have a history of **collagen** vascular disease? Yes No
Do you have **immunosuppression**? Yes No
Do you have Pacemaker or internal defibrillator? Yes No Do you have Shingles (blisters, itching and nerve pain)? Yes No Recent scars from operations (after 2 months it is possible)? Yes No Do you have Hypersensitivity of the skin after radiation therapy against cancer? Yes No Do you Use of certain medicines that are sensitive to light? Yes No Are you on Heavy anti-inflammatory medicine (hampers cells that need to normalize the skin, for example Prednisone)? Yes No Do you have Metals in or just below the skin where we treat? Yes No Do you have Pins or screws in joints and bones? Yes No Do you have Piercings (will have to get out)? Yes No Do you Tattoos (risk of fading of the tattoo)? Yes No Please circle any conditions you are suffering right now:
List **ALL** prescriptions and over-the-counter medications presently using: ____ ____ ____ ____ ____ ____

List **ALL DRUG,** food, latex or other substances allergies: ______________________________ ______________________________ ______________________________
List **ALL** surgeries and dates: ______________________________ ______________________________ ______________________________ ______________________________
Family Medical History (please check all that apply) Heart Disease/Stroke Diabetes High Cholesterol Obesity High Blood Pressure Cancer Other______________________________ ______________________________

Menstrual History:
Age at menarche? ____________________________
Last menstrual period?__________________________
Menstrual pattern? Regular Irregular
Cycle length? _______________________
Duration of flow?________________________
Amount of flow? ___________________________

Moliminal symptoms: Mark please
breast tenderness
food cravings
fatigue
sleep problems
headaches
fluid retention
Pain with menstruation
Intermenstrual bleeding

Vasomotor symptoms? Mark Please
night sweats
vaginal dryness
night sweats
weight gain
anxiety and depression
irritability

decrease libido

Contraception:
What is the Current method of birth control:
Are you satisfied with current method method?
What was your Previous methods?
Reasons previous method was discontinued?

Cervical and vaginal cytology:
Most recent Pap smear result: Normal Abnormal
History of abnormal Pap smears?
If so, nature of diagnosis, treatment, and follow-up

Infection:
History of sexually transmitted infections
History of vaginitis, including types, frequency, and treatment
History of pelvic inflammatory disease

Fertility/infertility
Desire for future fertility
Any difficulty conceiving in past?
If so, prior evaluation and treatments

Sexual history
Type (circle)? Bisexual Homosexual Heterosexual
Concerns about libido, dyspareunia (pain with sex), or orgasm?
History of sexual abuse or sexual assault?

Obstetric history
Describe each pregnancy and the outcome (circle): vaginal C-section Term Premature
Describe any maternal, fetal, or neonatal complications