

2733 86th St. Urbandale, IA 50322
 Phone 515.987-5188 • FAX 515. 987-8152

Name:		Last Name:		First Name:		Appointment Date:	
How were you referred to Urban Effects Medspa? (Circle All That Apply)							
Friend		Healthcare Provider:		Internet Search	Word of Mouth	Event	Gift Certificate
Facebook	TV	Vendor Website	Other	Please specify referral source: Search engine word, website, name etc.			
What is your reason for coming to Urban Effects today?							
We will not sell, share or rent your email address, or any other information collected on this form. We use email as a form of appointment confirmation and communication with our patients. You may opt in/out of any/all email communication at any time you choose. (Please print legibly)							
Email:							
Address:							
City/State/Zip:							
Telephone:		Cell: ()		Work: ()		Home: ()	
Date of Birth:		Mo/Day/Year / /		Occupation:			
Do you smoke?		Yes	No				
Do you have any allergies?		Yes	No				
If yes, please list:							
Are you pregnant?		Yes	No				
Are breast feeding?		Yes	No				
Are you trying to conceive?		Yes	No				
Please indicate if you had any of the following conditions by checking all that apply							
Hyperpigmentation		Keloids		Heart Disease		HIV	
Acne		Warts		Hypertension		Epilepsy	
Rosacea		Herpes, cold sores		Diabetes		Pacemaker/Defibrillator	
Inflammatory Skin Conditions		Skin Cancer		Thyroid Dysfunction		Immunological Problems	
Photosensitivity		Mole Removal		Cancer		Hepatitis	
Eczema		Skin Disease		Liver Disease		Mental Illness	
Psoriasis		Neuro-muscular Disease		Kidney Disease		Other:	
Have you ever taken Acutane for acne? If yes, when:							

Please complete the reverse side

Ethnicity:

Your Ethnicity			
Fathers Heritage		Mothers Heritage	
Medical Issues:			
Current			
Past			
Medications			
Previous Surgeries			
Skin Product Regimen Used at Home:			
AM			
PM			
Previous Spa Treatments: (Check)			
Facials	<input type="checkbox"/>	Peels	<input type="checkbox"/>
		Microdermabrasion	<input type="checkbox"/>
		Waxing	<input type="checkbox"/>
Previous Laser Treatments: (Check)			
Hair Removal	<input type="checkbox"/>	Vascular	<input type="checkbox"/>
		Resurfacing	<input type="checkbox"/>
Brown Spots	<input type="checkbox"/>	Improve Texture	<input type="checkbox"/>
		Skin Tightening	<input type="checkbox"/>
		Acne	<input type="checkbox"/>
Previous Dermatology Treatments: (Check)			
BOTOX®	Between Brows	<input type="checkbox"/>	Forehead
		<input type="checkbox"/>	Crow's Feet
		<input type="checkbox"/>	Other
		<input type="checkbox"/>	
Filler	Smile Lines	<input type="checkbox"/>	Cheeks
		<input type="checkbox"/>	Lips
		<input type="checkbox"/>	Other
		<input type="checkbox"/>	
Other			
Skin Concerns: (Check all that apply)			Other Concerns:
Wrinkles	<input type="checkbox"/>	Tired & Dull Look	<input type="checkbox"/>
		Acne	<input type="checkbox"/>
Mouth Lines	<input type="checkbox"/>	Dry Skin	<input type="checkbox"/>
		Melasma	<input type="checkbox"/>
Brown Spots	<input type="checkbox"/>	Anti-Aging	<input type="checkbox"/>
		Moles	<input type="checkbox"/>
Vascular	<input type="checkbox"/>	Oily Skin	<input type="checkbox"/>
		Painful Skin	<input type="checkbox"/>
Improve Texture	<input type="checkbox"/>	Large Pores	<input type="checkbox"/>
		Itchy Skin	<input type="checkbox"/>
Sagging Skin	<input type="checkbox"/>	Acne Scarring	<input type="checkbox"/>
		Stretch Marks	<input type="checkbox"/>
Lifestyle: (Circle)			
How many glasses of water do you drink per day? (8oz.)	<input type="checkbox"/>	0	<input type="checkbox"/>
		1-3	<input type="checkbox"/>
		4-5	<input type="checkbox"/>
		5 or more	<input type="checkbox"/>
How many times per week do you exercise?	<input type="checkbox"/>	0	<input type="checkbox"/>
		1-3	<input type="checkbox"/>
		4-5	<input type="checkbox"/>
		6-7	<input type="checkbox"/>
How would you assess your nutrition?	<input type="checkbox"/>	Poor	<input type="checkbox"/>
		Fair	<input type="checkbox"/>
		Good	<input type="checkbox"/>
		Very Good	<input type="checkbox"/>
Please assess your stress level	<input type="checkbox"/>	Low	<input type="checkbox"/>
		Avg.	<input type="checkbox"/>
		High	<input type="checkbox"/>
		Very High	<input type="checkbox"/>
Current Skin Care Products (Check what you use & list the brand)			
Cleanser	<input type="checkbox"/>		
Toner	<input type="checkbox"/>		
Moisturizer	<input type="checkbox"/>		
Exfoliator	<input type="checkbox"/>		
Sun Protection	<input type="checkbox"/>		
Topical Antioxidants	<input type="checkbox"/>		
Makeup	<input type="checkbox"/>		
Other (describe)	<input type="checkbox"/>		
Additional Comments and Concerns:			

The above information is true and accurate to the best of my knowledge

 Patient/Guest Signature

 Date