SEAVIEW
MEDICAL AESTHETIC BOUTIQUE

NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS [PLEASE INCLUDE CITY/STATE/ZIP] _____

EMAIL _____ OCCUPATION _____

PRIMARY PHONE _____ SECONDARY PHONE _____

HOW WOULD YOU LIKE US TO REACH YOU? ☐PRIMARY PHONE ☐SECONDARY PHONE ☐EMAIL

WHO MAY WE THANK FOR REFERRING YOU?

PHYSICIAN REFERRAL, WHO? _____ OTHER, PLEASE SPECIFY: _____

HAVE YOU HAD SERIOUS ILLNESS/INJURY/HOSPITALIZATION WITHIN 5 YEARS? _____

DO ANY OF THE FOLLOWING CONDITIONS APPLY TO YOU?

☐rheumatic heart disease	☐congenital heart disease	☐heart murmur	☐heart attack	☐coronary occlusion	☐stroke
☐diabetes	☐asthma	☐epilepsy	☐seizures	☐fainting spells	☐hepatitis
☐liver disease	☐arthritis	☐stomach ulcer	☐kidney disease	☐contact lens wearer	☐broken capillaries
☐cancer	☐rosacea	☐lupus	☐multiple sclerosis	☐bleeding disorders	☐varicose veins
☐fever blisters	☐spider veins	☐dry skin	☐oily skin	☐pregnant/lactating	☐herpes
☐neurological disorders	☐myasthenia gravis	☐sensitive skin	☐tanning beds	☐hyper-hypothyroidism	☐other:_____
☐smoker	☐use of chemical tanners	☐chronic pain	☐psychiatric disorder	☐history of eating disorder	_____
☐constipation	☐history of substance abuse	☐family history of breast cancer		☐hypertension (high blood pressure)	

HAVE YOU HAD ANY OF THE FOLLOWING?

☐sclerotherapy	☐spider vein removal	☐chemical peel	☐hysterectomy	☐laser treatment	☐facial surgery
☐accutane therapy	☐hormone replacement	☐steroid therapy	☐hair reduction	☐waxing	☐retin A
☐birth control pills	☐BOTOX or Dysport	☐skin rejuvenation	☐electrolysis	☐radiation	☐IPL
☐liposuction	☐dermal fillers	☐fat transfers	☐depilation	☐microdermabrasion	☐pacemaker
☐permanent cosmetics	☐cellulite treatment	☐blood transfusion	☐abnormal bleeding	☐deep vein thrombosis	

☐cosmetic surgery: type _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS/ANESTHESIA? IF YES, PLEASE SPECIFY _____

WHAT MEDICATIONS DO YOU TAKE DAILY? [INCLUDE ALL SUPPLEMENTS/HERBAL REMEDIES]

I have answered all questions truthfully and revealed all of my medical conditions and agree to alert SEAVIEW Medical Aesthetic Boutique, LLC of all changes that occur. I also consent to being photographed as an aid to my treatment and that my photographs may be used for study reporting. I am aware that all information, including photographs are confidential.

SIGNATURE _____ DATE _____