MENON
Regenerative Institute

Name:		Date:	Occupation:
Address:		Phone:	Date of Birth:
City:	State:	Zip Code:	Email:
Cell: Phone:	Contact me by __Text	Cell	Emergency Contact:
How did you hear about us:			Referral Name:

General Health

1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1
2. Are you pregnant or nursing? Yes No
3. Do you wear contact lenses? Yes No
4. Do you smoke? Yes No How many cigarettes per day?
5. Please list any accidents or surgeries in the last 9 months:
6. Do you have any metal implants, a pacemaker or body piercings?
7. List the medications you are currently taking:

Prescription	Over the Counter

Health History

Heart Condition	Lymph Edema	Herpes/Shingles	High Blood Pressure	Low
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain	
Rashes	Jaw Pain/TMJ	Blood Clots	Constipation	
Diabetes	Gas/Bloating	Headaches	Arthritis	
Broken/Fractured Bones	Pregnancy (___ weeks)	Fatigue/Sleep Disorder	Depression/Anxiety	

Other (explain): Undergoing Cancer treatment

Skin Care

1. Are you under the care of a dermatologist? Yes No
2. Do you use: Accutane Retin-A Renova Adapalene Other prescription skin products _____
3. Have you had a: Chemical Peel Microdermabrasion Botox Other resurfacing treatments
4. Are you currently using any products that contain: Glycolic Acid Lactic Acid Hydroxy Acid Vitamin A
5. Do you have any skin sensitivities or irritants

Skin Maintenance
Products You Use: Soap Cleanser Toner Moisturizer Exfoliator Masque
Skin Type: Oily/Congested Dry/Dehydrated Sensitive/Redness Acne Sunburned
Eczema Claustrophobia Psoriasis Iodine or Shellfish
Have you been tanning in the last 24 hours? Yes No Are you going or coming from a vacation? Yes No
What are your skin care goals?

It is my choice to receive these Services from Menon Regenerative Institute. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update the staff at Menon Regenerative Institute of any changes to my health status. The office is not responsible for any side effects from treatment (pain, burns, pigment changes, discoloration, etc).

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24hour notice, I agree to pay the missed appointment fee that applies.

Name

Date