Allureous, LLC Medical Spa & Clinic
13179 Black Mountain Road #5, Suites 130-131
San Diego, CA. 92129

Patient Information & Intake

Date _____
Name _____
First Middle Last
DOB _____
Address _____
Home Telephone _____ Cell Number _____Work Phone _____
Email _____
Occupation _____ Marital Status: _____
How did you hear about us? _____
Ethnic Background: (Circle all that applies)
Caucasian Hispanic Italian Indian African-American Asian Others: _____
Emergency Contact:

- Name _____ Relationship _____
- Contact Number _____

Current Medical History: Please state the reason(s) for your visit and describe any symptoms you are experiencing:

_____

Recent Botox or Dermal Fillers in the last 2 weeks?	**Y**	**N**	**NA**
Recent Tanning in the last 2 weeks?	**Y**	**N**	**NA**
Accutane Use in the last 6 months?	**Y**	**N**	**NA**
For Female: Pregnant or Lactating?	**Y**	**N**	**NA**

LMP: _____

Surgeries/Hospitalizations

Surgeries/Procedures	Year

Medications/Supplements

Medication/Supplement	Reason for taking	Date Began	Dose

Have you had any allergic reaction or sensitivity to the following:

Local Anesthesia (ex. Lidocaine, Tetracaine)	Y	N
Penicillin or other antibiotics	Y	N
Sulfa Drug	Y	N
Latex	Y	N
Iodine	Y	N
Aspirin	Y	N

Foods	Y	N
Gram Positive Bacteria Protein	Y	N
Hyaluronic Acid	Y	N
Others	Y	N

If YES, please explain: _____

FAMILY history: Do your parents or siblings have any medical conditions?

_____

List Y (Yes), N (No) or P (Past) regarding use of the following:

Steroids	Y	N	P	If yes, for what condition & dose? _____
Smoking	Y	N	P	If yes, how much per day? _____
Alcohol	Y	N	P	If yes, how much per day?_____
Caffeine	Y	N	P	If yes, how much per day? _____
Recreational Drugs	Y	N	P	If yes, what kind? _____

Have you had or currently experiencing any of the following?

Acne	Y	N	Lambert-Eaton Syndrome	Y	N
Amyotrophic Lateral Sclerosis	Y	N	Leukopenia	Y	N
Anemia	Y	N	Liver Disease	Y	N
Anxiety	Y	N	Low Blood Pressure	Y	N
Asthma	Y	N	Lupus/SLE	Y	N
Bleeding/Clotting Disorder	Y	N	Lymph Node Disorder	Y	N
Bleeding Tendency	Y	N	Metal Implants	Y	N
Bruising Easily	Y	N	Migraines	Y	N
Cancer Active	Y	N	Myasthenia Gravis	Y	N
Cancer-Remission	Y	N	Multiple Sclerosis	Y	N
Cardiac Disorder	Y	N	Pacemaker/Defibrillator/Implant	Y	N
Cataract	Y	N	Permanent Make-up or Tattoos	Y	N
Cold Sores	Y	N	Polymyalgia Rheumatica	Y	N
Current Cold/Flu	Y	N	Poor Wound Healing	Y	N
Depression	Y	N	Raynaud's Disease	Y	N
Diabetes	Y	N	Respiratory Disease	Y	N
Epilepsy/Seizures	Y	N	Rheumatoid Arthritis	Y	N
Glaucoma	Y	N	Scleroderma	Y	N
Hepatitis Type ____	Y	N	Shingles	Y	N
High Blood Pressure	Y	N	Sjogren's Syndrome	Y	N
High Cholesterol	Y	N	Skin Rash, currently	Y	N
HIV	Y	N	Staph Infection/MRSA	Y	N
Infection Currently	Y	N	Stroke	Y	N
Keloid Scarring	Y	N	Thyroid Disorder	Y	N
Kidney Disease	Y	N			

Other Conditions_____

If you answered YES to any of the above conditions, please state how this is being managed:_____

Primary Physician _____Telephone Number _____

Client's Printed Name _____ Date _____

Client's Signature _____ Date _____

Provider's Printed Name _____ Date _____

Provider's Signature _____ Date _____