SBC
Shonan Beauty Clinic

Consultation and Medical History Form

Date: _____ **Reason for Visit:** _____

Patient Information

First Name:	**Last Name:**	**Middle Name:**
Date of Birth:	**Sex:**	**Occupation:**

Ethnicity: ☐Asian ☐American Indian ☐Black or African American ☐Caucasian ☐Hispanic/Latino ☐Middle Eastern ☐Native Hawaiian/Other pacific islander ☐Other ☐Prefer not to answer

Street Address:	**City:**	**State:**	**Zip code:**

Cell Phone:	**Email:**
Home Phone:	

Please Check All Procedures That Interest You

- **Laser hair removal**
- **Tattoo removal**
- **IPL**
- **Micro needling**
- **ThermiVa**
- **Pico spot**
- **Pico Toning**
- **Pico Fractional**
- **Coolsculpting**
- **DEP-Collagenizer**
- **ThermiSmooth**
- **Erbium**
- **Botox**
- **Filler**
- **Thread lift**
- **Maibotsu**
- **Labiaplasty**
- **Blepharoplasty**
- **Liposuction**
- **Other(_____)**

Primary Care Physician (PCP)

PCP Name:	**Phone:**
Address:	

EMERGENCY CONTACT

Emergency Contact Name:	**Relationship:**
Phone:	**Alternate Phone:**

Pharmacy Information

Pharmacy Name:	**Phone:**
Address:	

Pregnancy

Are you or are you planning to become pregnant within 12 weeks?

☐**NO** ☐**Yes**

Media

How did you find us?

☐**Google** ☐**Instagram** ☐**Facebook** ☐**Yelp** ☐**Homepage** ☐**Vivinavi** ☐**Lighthouse** ☐ **Email News letter**

☐**Friends & Family / Acquaintances** ☐**RED** ☐**WeChat** ☐**Other (_____)**

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Medical History

○ High Blood Pressure	○ Asthma	○ Hepatitis	○ Seizure
○ Diabetes	○ Depression	○ HIV	○ Poor wound healing
○ Stroke	○ Anxiety	○ Bleeding Disorder	○ Thyroid Disease
○ Heart Attack	○ Other Psychiatric Condition	○ Anemia	○ Liver Disease
○ Heart Disease		○ Sleep Apnea	○ Lung Disease

Please list any other medical conditions (Either currently or in the past):

Please list all current medication and dosage (Include over the counter/vitamins/supplements):

Please list allergies and associated reactions: **Allergy to latex? Yes/No**

Please list prior surgeries, hospitalizations, and all aesthetic treatments. (Include dates, and if any complications):

Social History

Do you smoke?	**No /**	**Yes**	**If yes, how frequently?**
Do you consume Alcohol?	**No /**	**Yes**	**If yes, how frequently?**
Do you use illicit drugs?	**No /**	**Yes**	**If yes, how frequently?**

Family History

Does a member of your family have a history of any of the following?

Bleeding Disorder **No / Yes**

Poor Wound Healing **No / Yes**

Reaction to Anesthesia **No / Yes**

I certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Name of Patient or Representative | Signature of Patient or Representative | Date

22 Odyssey, Suite 200 Irvine CA 92618. Email: info.ir@shonanbeauty.com Phone: 949-333-2929333-2929

Please see back side of this form