S.K.I.N. Spa
BOBBI EDWARDS, M.D., P.C.

Name_____Date_____

Address_____

City_____State_____Zip Code_____

Home_____Work_____Cell_____

Medical: Are you currently or within the last year under any Doctors care?
□ No □ Yes – Explain_____
Health Problems □ Diabetes □ Thyroid □ Heart □ Cancer □ High/Low Blood Pressure□ Epilepsy □ HIV □ Other_____
Medications, & Vitamins – List all and what they are for:

_____

_____

Do you take: □Diet pills □Stimulants □Oral Contraceptives □Laxatives □Diuretics
Do you smoke: □No □Yes
Have you had dental xrays within the last 2 weeks? □ No □Yes
Have you undergone surgery recently? □ No □Yes
Do you have any metal implants? □No □Yes
Do you exercise regularly? □No □ Yes
What is your consumption of water of: Water____oz Coffee_____oz Tea____oz
Soft Drinks (Reg/Diet)_____oz Other____oz
What water temperature do you cleanse with □Cold □Warm □Hot
Areas of Concern (Be specific, please):_____
Have you ever had any Allergic Reactions? □No □Yes_____
Do you ever experience skin break-outs? □No □Yes_____

Personal skin care: □Soap □ Cleanser □Toner □Scrub □Masque □Moisturizer
□Sunscreen SPF#_____ □Other_____
Do you blush easily? □No □Yes Sunburn easily? □No □Yes Redness tendency □No □Yes
Massage preference? □Firm □Light Sinus problems? □No □Yes
Pain threshold □Low □Med □High
Who referred you?_____

FEMALE CLIENTS ONLY: Are you trying to become pregnant? □No □Yes
Are you due for your menstrual period with the next week? □No □Yes

Cancellation requests must be made no less than 24 hours before the appointment time. Missed appointments will generate a cancellation fee equal to 50% of the cost of your scheduled service.

Signature_____ Date_____