Our Spa

Welcome! We are excited that you have taken time to come to our spa and look forward to getting to know you. Flawless has been treating people in Albuquerque for over 7 years. We specialize in laser treatments, cosmetic injections and skin care that help your body naturally repair itself. Your safety is our priority and will do everything we can to make your experience exceptional. We know aging is a natural process, however, the advancements we have made with technology & skin care can help tremendously. Thank you for trusting us with your care and being part of your journey. – Heather Badal

Name: _____ Date:_____

Cell Phone:

_____

Home Phone: _____

Date of Birth: _____

Occupation: _____

Home Address: _____

City/Stat/Zip: _____

Emergency Contact Name and Phone: _____

Email: _____

How can we help you?

LASER TREAMENTS	COSMETIC INJECTIONS	SKIN CARE	AESTHETICIAN
☐ Hair Removal	☐Minimize Crows Feet	☐ Manage Acne	☐Chemical Peels
☐ Tattoo Removal	☐ Forehead Lines	☐ Help Oily Skin	☐ Dermaplaning
☐ Acne Scar Repair	☐ Fuller Lips	☐ Care for Combo Skin	☐ Microneedling
☐ Melasma	☐ Reduce Double Chin	☐ Nourish Dry Skin	☐Facials
☐ Age Spot Removal	☐ Fine Lines around Lips	☐ Prevent Dark Spots	☐Exfoliate My Skin
☐ Skin Damage Repair	☐ Enhance Cheek Bone	☐ Repair Sun Damage	
☐ Facial Spider Veins	☐ Hollowness Under Eyes	☐ Slow Down Aging Process	
☐ Skin Tightening	☐ Define Jaw Line	☐ GloMinerals Make Up	
☐ Reduce Pores & Improve Skin Texture			

Do you smoke e-Cigarettes, Cigarettes or Use Vapor Pens? ☐ No ☐ Yes

How did you hear about us?

☐ Walking By ☐Yelp ☐ Google ☐Flawless Web page ☐ Radio ☐Billboard ☐Mailing ☐ A Friend

Please tell us so we give them a special thanks:

_____

Nursing Notes

Patient smokes cigarettes, uses a vapor pen or e-cigarettes ___ Daily ___ Weekends ___ 1/Month ___ Never

Fitzpatrick Skin Type: 1 2 3 4 5 6 Photo Taken: Yes No/ Refused

Number of Tattoo(s): _____ Size of Tattoo(s): _____ Location on Body:

_____

Areas for Hair Removal: _____ Areas for PicoSkin:_____

Skin Concerns: _____ Recommended Products: _____

Recommended Units: _____ Fillers: _____

_____

_____

_____

_____

_____

_____

Medical History

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Chemotherapy
☐ Autoimmune Diseases	☐ Blood Clots	☐ Cancer	☐ Lupus
☐ Cold sores	☐ Depression	☐ Diabetes	☐ Autoimmune Diseases
☐ Herpes	☐ Heart Disease	☐ Migraines	☐ Respiratory Issues
☐ High Blood Pressure	☐ PCOS	☐ Raynaurd's	☐ Sensitivity to the sun
☐ Skin Pigmentation Changes	☐ Seizures	☐ Thyroid	☐ *OTHER (please list below)*

Do you have a pacemaker? ☐ No ☐ Yes

Are you taking any Blood Thinners ☐ No ☐Yes

Are you taking any supplements? ☐ No ☐ Yes

Are you using Retin A or Tretinoin? ☐ No ☐ Yes

Are you using Hydroquinone? ☐ No ☐ Yes

Are you on birth control or hormone replacement? ☐ No ☐Yes

Are you Pregnant, trying to get pregnant or lactating? ☐ No ☐Yes

I consent to having my photo taken and used for medical purposes and promotions ☐ No ☐ Yes

Tattoo Removal Consultations

Have you received previous tattoo removal treatments in the past? ☐ N/A ☐ No ☐ Yes

Does your tattoo(s) itch or every get hives (important for red & blue ink)? ☐ N/A ☐No ☐ Yes

Are you receiving or have you ever had Gold Therapy? ☐ N/A ☐ No ☐Yes

How many tattoos will we be removing?

_____

Where are the tattoos on your body?

_____

Laser Hair Removal Consultations

Have you received previous laser hair removal treatments on the area? ☐ N/A ☐No ☐ Yes

What areas on the body are you interested in treating (face, legs etc)?

_____

When was the last time you waxed, plucked or tweezed the area?

_____

Allergies, Medications & Surgeries

Have you ever had an allergic reaction to any of the following? Please List Below ☐ No ☐ Yes

☐ Eggs/Food ☐ Cow's Milk ☐ Food ☐ Latex ☐ Aspirin ☐ Lidocaine ☐ Red Dye ☐ OTHER

_____

_____

What oral medications are you presently taking? Please include supplements and vitamins. If you start any NEW medications during you treatments, please let us know. Some make you sensitive to light.

_____

_____

_____

_____

Please List any surgeries in the last 5 years.

_____

_____

_____

I certify that I have answered the medical history questions truthfully and completely. I am aware that it is my responsibility to inform the Nurse, Aesthetician, and Receptionist of any changes in my health and medications. I understand that I need to update Flawless with any changes in my medication and health.