

O'Leigh Med Spa & Laser Center: New Client Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Date of Birth _____ Age _____ Referred by _____

Nail Services

Have you ever used acrylic nails? No Yes, in the past Yes, currently

Have you ever had any reaction to any of the following? Cosmetics Medicine

Aspirin Fragrance Sunscreen Pollen Iodine AHAs

Animals Food _____ Other Allergies _____

Do you have any active infections? Yes No

Are you pregnant? Yes No

Are you currently seeing a physician for a specific medical reason? Yes No

If yes, please explain _____

Do you currently take any medications or vitamins? Yes No

If yes, please specify _____