



Ismael A. Beloso, D.O.
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Name _____ Male ___ Female ___ Today's Date _____

Birth Date _____ Age: _____ Email: _____

Home Address _____

City _____ State _____ Zip Code _____

Best Phone #: _____ Other Phone # _____

Occupation: _____ Married? Yes ___ No ___ Spouse's Name: _____

In case of an emergency: Name _____ Relationship _____

Best Phone #: _____ Other Phone # _____

Where did you hear about CHANGES Medical & Wellness Spa?

Friend or Family Member, Name: _____

Physician Referred, Name: _____

Radio TV Newspaper Internet Local Event Other _____

How do you preferred to be contacted? Phone Email _____

Would you like to receive special offers and promotions from CHANGES via email? Yes No

What are your three favorite radio stations? _____

What are your three favorite websites? _____

Describe the nature of your visit to CHANGES Medical & Wellness Spa: _____

What are your expectations? _____



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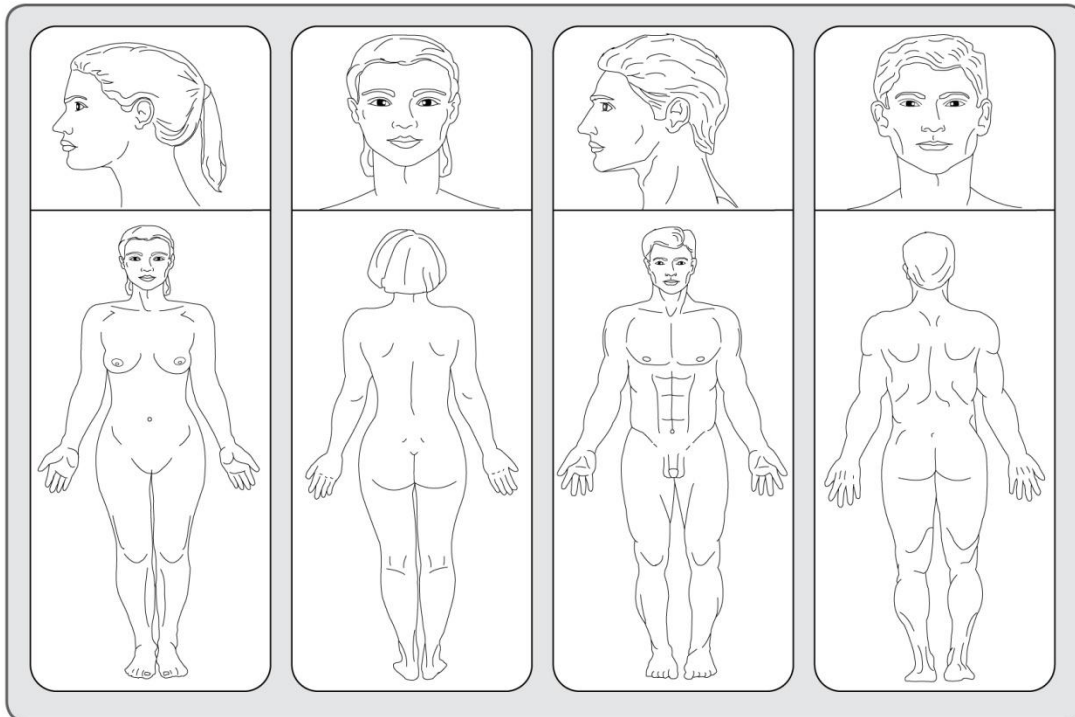
Please Tell Us About Yourself....

Have you ever had laser treatments or cosmetic procedures? Yes No

If yes, explain: _____

Please circle the areas you need treated on the diagram below:

- FACIAL** **LASER HAIR REMOVAL** **LASER SKIN RESURFACING**
PIGMENTED LESION OR BROWN SPOT REMOVAL **NON-ABLATIVE LASER FACIAL**
WAXING **CHEMICAL PEEL** **MICRODERMABRASION** **OTHER: _____**



In order to better establish your skin type, please tell us your race/ethnicity: _____



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Please circle your skin type that best describes your skin type:

- Skin Type I Never tans, always burns (extremely fair skin, blonde hair, blue/green eyes)
- Skin Type II Occasionally tans, usually burns (fair skin, sandy/brown hair, green/brown eyes)
- Skin Type III Often tans, sometimes burns (medium skin, brown hair, brown eyes)
- Skin Type IV Always tans, never burns (olive skin, brown/black hair, dark brown/black eyes)
- Skin Type V Never burns (dark brown skin, black hair, black eyes)
- Skin Type VI Never burns (black skin, black hair, black eyes)

Is your skin sensitive? Yes___ No___ Are you using chemical tanning solutions? Yes___ No___

Have you had any sun exposure or tanning bed in the past 3 days? Yes___ No___

If so, are you sunburned? Yes___ No___ Do you use tanning beds? Yes___ No___

MEDICAL HISTORY: (Please circle yours answers)

How would you describe your general health? GOOD FAIR POOR

Have you had a major illness or been hospitalized within the last 5 years? YES NO

Please describe: _____

Are you currently using any medications? (Topical, Ingestible, or Injectable) YES NO

Please list all medications: _____

Do you have acne? YES NO Are you taking Accutane? YES NO

Have you taken Accutane in the last 6 months? YES NO

Are you using Rogaine, Propecia, Minoxidil? YES NO If yes, please list: _____

Are you using steroids? YES NO



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Have you ever had gold injections? YES NO Are you allergic to Latex? YES NO

Does your skin have spider veins? YES NO If yes, where? _____

Are you allergic to any medications? YES NO

Please list medication allergies: _____

Are you taking Aspirin, Advil, Motrin, or any other over the counter medications? YES NO

List: _____

Are you taking any herbal or vitamin supplements? YES NO List: _____

Do you use tobacco? YES NO Type: _____

Do you consume more than two alcoholic beverages per day? YES NO

Have you ever had any of the following?

Skin Cancer or Pre-Cancer: Basal cell Dysplastic Nevus Squamous Cell Melanoma

If yes, when: _____ Where on the body? _____

WOMEN ONLY: (please circle your answer)

Are you pregnant? YES NO

Are you trying to become pregnant? YES NO

Are you taking oral contraceptives? YES NO

Expected Delivery Date: ____ / ____ / ____

Are you currently nursing? YES NO

