

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY			
Client Name		_Today's Date_	
Date of BirthAge	_Occupation		
Home Address	City	State	Zip Code
Home Phone ()	Work Phone ()	
Emergency Contact Name and Phone_			
Email Address			
How were you referred to us?			
MEDICAL HISTORY			
Are you currently under the care of a p	hysician?Yes	No	
If yes, for what:			

Do you have any of the following medical conditions? (Please check all that apply)

_Cancer	_Diabetes	_High blood pressure	_Herpes	_Arthritis
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_Frequent cold sores _HIV/AIDS _Keloid scarring _Skin disease/Skin lesions

_Seizure disorder _Hepatitis _Hormone imbalance _Thyroid imbalance

_Blood clotting abnormalities _Any active infection _Do you smoke?

_Thyroid disease _Circulatory problems _Tumors/Growths

Do you have any other health problems or medical conditions? Please list: ______



Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) _Food _Animal Protein _Aspirin _Lidocaine _Hydrocortisone _Hydroquinone or skin bleaching agents _Others:

MEDICATIONS

What oral prescription	medications are you presently taking?	_Birth control pills	_Hormones
_Steroids _Others (It i	s required that you list all of them):		

Surgical History. Please list all surgeries.

IPL/Laser History. Please list all treatments.

Liposuction History. Please list.

Have you had complication or bad reactions to anesthesia? _Yes _No

Are you on any mood altering or anti-depression medication?

What topical medications or creams are you currently using? _ RetinA , _Others (Please list):

What herbal supplements do you use regularly?_____ Have you ever had an allergic reaction to the following? _ Latex _Lidocaine _Anesthesia _Topical Anesthesia _Others

GENERAL QUESTIONS

When did you last tan your skin? ______

	When were you last exposed to sur	, tanning beds, creams?	
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Have you had any of the following injections or fillers?	_Collagen	_Botox	_Dermal Filler	_Other
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Date of last treatment.



Do you have any problems with hypopigmentation or hyperpigmentation? _Yes _No

Have you ever had sclerotherapy?

When a scar appears on your skin, is it significantly dark in color?

SKIN TYPE

 $\label{eq:combination} Ethnicity: _White _Asian _Hispanic _Mediterranean _Middle \ Easter _Black _Combination$

Which of the following best describes your skin reaction when you are in the sun?

_Type 1: always burns, never tans. Red hair, blonde hair, light eyes.

_Type 2: somewhat tans, mostly burns.

_Type 3: sometimes burns, mostly tans, also known as olive complexion.

_Type 4: rarely burns, almost always tans, also known as olive complexion.

_Type 5: moderately pigmented (Indian, Persian, light African-American.

_Type 6: African-American

Do you wear sunscreen? _Never _Sometimes _Always

Skin Care Regimen: Please specify products you are currently using:

HISTORY <u>For our female clients:</u> Are you pregnant or trying to become pregnant? _Yes _No Are you breastfeeding? _Yes _No Are you using contraception? _Yes _No



I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Name (Print)

Client Signature

Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print)

Doctor Signature

Date