

NEW PATIENT INFORMATION/MEDICAL QUESTIONNAIRE

Today's Date ____/____/____ (General questionnaire for all procedures some questions may not be relevant)

Last Name _____ First _____ MI _____

Address _____

_____ Zip Code _____

Phone #1: _____ Phone #2: _____

E-mail Address _____

Occupation _____

Approximate Weight: _____ Height: _____ Date of Birth ____/____/____

Please list the prescriptions you are currently taking: _____

Drug Allergies: _____

Please list previous surgeries: _____

Goal or Reason for Visit:

- | | |
|--|--|
| <input type="checkbox"/> Laser Liposuction | <input type="checkbox"/> Zeltiq CoolSculpting |
| <input type="checkbox"/> Medical Supervised Diet | <input type="checkbox"/> Fraxel & Fractional CO2 |
| <input type="checkbox"/> Thermage / Ultherapy | <input type="checkbox"/> Botox |
| <input type="checkbox"/> Restylane / Juvederm / Radiesse | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> IPL - Photofacial | <input type="checkbox"/> Laser Tattoo Removal |
| <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Microdermabrasion |

Have you ever had a cold sore on your lip? No Yes Last time:

Do you have a history of easy bruising or bleeding problems? No Yes

Do you have a history of darkening of the skin after injury? No Yes

Are you pregnant or breastfeeding? No Yes

Have you used or are you currently using Retin-A or Renova? No Yes Last time:

Have you used or are you currently using Accutane? No Yes Last time:

I have been given the opportunity to review the HIPAA notice either online or in-office.

Signature: _____

MICRODERMABRASION / CHEMICAL PEEL QUESTIONNAIRE & CONSENT

Today's Date ____/____/____

Last Name _____ First _____ MI _____

Please list the products you are currently using: _____

Drug Allergies: _____

Have you had any type of exfoliation in the past 2 weeks? If yes, please list the type:

Please respond yes or no to the following questions:

- | | | |
|--|------------------------------|--|
| Pregnant or nursing? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Sun exposure in the last 2 weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Plan on sun exposure in the <u>next</u> 2 weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Use Retin-A? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO Last time: _____ |
| Use Renova? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO Last time: _____ |
| Vitamin C? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO Last time: _____ |
| Glycolic Acid? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO Last time: _____ |
| Accutane? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO Last time: _____ |

CONSENT:

I understand that the results from a microdermabrasion/glycolic peels treatment are not guaranteed and results will vary. In order to achieve optimum results, I understand that a series of treatments is required.

I will alert the staff if I am pregnant or have an allergy to Aspirin.

I understand that the skin may be irritated for several days after a peel, and there may be some small pinprick bleeding and bruising as a result of the treatment. I should not receive either treatment if I have had Botox in the last 24 hours, but can have it AFTER the treatment is completed.

Possible side-effects to treatment are: local swelling, stinging, tenderness, flaking, peeling, lightening or darkening of the skin and/or mild to moderate redness. It is possible that one or more of these side effects may last for two (2) to seven (7) days post procedure. However, most subside within 24 hours. I understand, as with all skin exfoliation treatments there is the slight risk of hyper-pigmentation, scarring and bruising with this treatment, it is also possible to break capillaries (facial blood vessels), which can be permanent. I have been advised to disclose to if I am prone to Herpetic outbreaks (cold sores/fever blisters). I understand that acid treatments and/or microdermabrasion may cause a flare-up of the Herpes Simplex virus.

I will follow all post care instructions that are given and wear a sun block with no less than an SPF 30 while receiving treatment. To the best of my knowledge, all the above information I have given is correct.

This consent is valid for all future sessions and I will alert the staff if there are any changes to my medical history.

Clients Signature _____ Date _____

Therapist Signature _____ Date _____