LONDON MEDICAL SPA

Client Information and Medical History

Name____Today's Date________________

Birthdate______________ Age ____ Occupation______________________________

Home Address____________________ City_____________ State ______ Zip __________

Phone______________________ Email____

Emergency Contact ___________________________________Phone__________________

How were you referred to London Medical Spa?_____________________________________

What treatments are you interested in? *Please circle all that apply*

Wrinkle and Line Reduction Dermal Fillers Chemical Peels Laser Resurfacing Leg Vein Treatments

Skin Tightening Micro-Needling Acne Mole or Skin Tag Removal Scar Treatments Dark Spot Removal

Tattoo Removal facial droop Neurotoxin (Botox or Dysport) Earlobe Repair Ear Piercing

What cosmetic treatments have you had in the past? _________________________________

Have you ever had an undesirable outcome from a cosmetic procedure in the past?___________

What statement best describes your skin type (without sunscreen)? *Circle your type*

1. Always burns, never tans *3. Sometimes Burns, always tans* *5. Brown skin*

2. Always burns, sometimes tans *4. Rarely Burns, always tans* *6. Black skin*

Have you had a deep chemical peel or laser treatment within the past 3 months? Yes No

Do you form thick or raised scars when your skin is injured? Yes No

Do you develop light or dark spots after your skin is injured? Yes No

Are you pregnant or nursing? Yes No When was you last normal Menstrual cycle? ________

Do you have allergies? Please list your allergies: __________________________________

Are you allergic to any of the following: Yes No *lidocaine tetracaine benzocaine fillers Botox Dysport milk rubbing alcohol skin bleaching agents aspirin*

Do you have a bleeding disorder or are you on blood thinners? Yes No

Do you currently have or ever had any of the following medical conditions: C*ircle all that apply*

Pacemaker defibrillator	*Impaired immune system*	*Cancer*
Blood clotting disorder	*Keloid scarring*	*Hepatitis*
Heart valve replacement	*Diabetes*	*MRSA infections*
Hormone imbalance	*Thyroid imbalance*	*Active skin infection*
Heart disease	*Lung disease*	*Asthma*
Neurologic disorder	*HIV/AIDS*	*Metal implants*
Skin diseases	*Varicose veins*	*High blood pressure*
Bipolar disorder	*Depression*	*Anxiety*

Do you have **any other problems** or medical conditions? Yes No *Please list and explain:*

____

____

Do you get **fever blisters**? Yes No

Do you get MRSA skin infections? Yes No

Do you now have or ever had a skin cancer? Yes No

List current medications: ____
use back of page if needed

Have you ever taken the acne pill Accutane in the last year? Yes No

What topical medicines or creams are you currently using? Retin A Tazorac
Retinoic acid Tretinoin Others (please list) ___________________________________

How often do you apply sunscreen? ____

MEDICAL HISTORY DISCLAIMER

A current medical history is essential for the caregiver to execute appropriate, safe treatments and procedures. I certify that the preceding medical, personal and skin history statements are true and accurate. I am aware that it is my responsibility to inform the physician and staff of my current medical or health conditions and to update this history at EVERY VISIT to make him aware of any health changes.

Patient Signature____Date_______________

Reviewed by ____Date_______________

SKIN CANCER DISCLAIMER
Your treatments at London Medical Spa are for cosmetic enhancement of your skin only. I understand that it is my responsibility to seek the care of a dermatologist for any concerns regarding skin cancer and treatment of suspicious areas of my skin.

Patient Signature____Date_______________

RELEASE FOR USE OF PICTURES AND MEDICAL INFORMATION
I agree that Dr. London and or designated associates may take photographs and or video tapes of me during and or immediately after my procedure as well as subsequent office visits. I also agree to allow use of some elements of my medical history, such as my age and services received, to support the photo images. I understand that these photographs may be published in a variety of sources including all forms of social media. In such an event, I will not be identified by name. I expect no compensation for these photographs and or videos and waive all rights to claims for payments or royalties. I also release London Medical Spa and its associated staff from any liability in connection with use of such photographs and videos. I understand that by allowing use of my photos I am waiving my rights under HIPPA. I understand that at any time I may request, in writing, to have any of these images removed from advertisement.

Patient Signature____Date________________

VIDEO CONSENT
Your treatments and interactions at London Medical Spa may be videotaped for your protection and ours. The videos are purely for medical legal protection and **WILL NEVER BE USED OR SHARED FOR PROMOTIONAL PURPOSES.** This release is irrevocable. I hereby allow Dr. London and London Medical Spa to create a video record of my interactions and treatments to be stored indefinitely.

Patient Signature____Date_______________

Results: I understand that the actual degree of improvement from treatments cannot be predicted or guaranteed. Furthermore, I understand that the effect will gradually wear off and additional treatments may be necessary to maintain the desired effect.

Refund Policy: I understand that refunds will not be issued for services rendered or products used during treatments.

Patient signature _______________________________________ Date______________

Reviewed by ____ Date______________