DS-DiAngelis Skin and Lips

**Client Medical History and Physical Assessment**

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 Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (opt) (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? No Yes Amt: \_\_\_\_\_\_\_\_ Regular Exercise? No Yes Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E mail Address for monthly specials or other important information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Note: we will not send spam email, nor will we share your email with any other party**

Please circle the method you prefer us using when confirming your appointments: Cell / Home / Work / Email

Emergency Contact Name and Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To whom should we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name/City & State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health issues and procedures or products of interest to you (please check all that apply).**

* BOTOX Cosmetic™ (Botulinum Toxin Type A)  Skin Care Advice
* AHA and Glycolic Peels  Skin Care Products
* Collagen Therapy  Birthmarks
* Skin Rejuvenation  Liver Spots/Age Spots
* Avage™, Retin-A or Renova  Sunscreen Advice
* Micro-Dermabrasion  Removing Leg Veins
* Acne  Facials and Eye Treatments
* Chemical Peels  Hair Removal
* Laser Resurfacing  Spider Vein Treatments
* Laser Treatments  Removing Facial Veins
* Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fitzpatrick Skin Type**: (circle one)

 1) I - Always burns, never tans 2) II - Always burns, sometimes tans

 3) III - Sometimes burns, always tans 4) IV Rarely burns, always tans

5) V - Brown, moderately pigmented Skin 6) VI - Black skin

**Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.**

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than True Age Older Than

 1 2 3 4 5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

 Not Concerned Somewhat Concerned Very Concerned 1 2 3 4 5

**History of Cosmetic/Aesthetic Procedures:**

Have you ever had any facial surgery performed? NO YES TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following injectable procedures done? (circle)

Botox Juvederm Restylane Radiesse Collagen Sculptra Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any type of Chemical Peel? NO YES TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had laser hair removal? NO YES TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any type of laser treatment (other than hair removal)? NO YES TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any *recent* tanning or sun exposure that changed the color of your skin? NO YES \_\_\_\_\_\_\_\_\_\_

Have you *recently* used any self-tanning lotions or treatments? NO YES TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MEDICAL HISTORY

Are you currently under the care of a physician (*for other than annual exams*?) NO YES If YES for what:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a dermatologist? NO YES

If YES for: Annual Exams OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following medical conditions? (Please check all that apply) NONE

|  |  |
| --- | --- |
| □ Cancer  | □ Diabetes □ High blood pressure  |
| □ Herpes  | □ Arthritis □ Frequent cold sores  |
| □ HIV/AIDS  | □ Skin Cancer □ Skin disease/Skin lesions  |
| □ Seizure Disorder  | □ Hepatitis □ Hormone Imbalance  |
| □ Any Active Infections  | □ Acne □ Rosacea  |
| □ Thyroid Imbalance  | □ Blood clotting/bleeding abnormalities  |

Do you have any other health problems or medical conditions (not listed) that may help us in your treatment plan?

 NO PROBLEMS: PLEASE LIST:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH HISTORY:**

 Please note the following questions refer to your entire life history, not just your current situation.

Have you ever talked to a psychiatrist, psychologist, therapist, social worker or counselor about an emotional

problem? NO YES

Have you ever felt you needed help with your emotional problems, have you ever had people tell you that you should get help for your emotion problems, AND/OR have you ever been advised to take medication for anxiety, depression or

for any other emotional problems? NO YES

Have you ever had nightmares or flashbacks as a result of being involved in some tramatic/terrible event?

 NO YES

Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or

unsteady as if you would faint? NO YES

Have you ever considered yourself the “unlucky one” or felt that if something bad was going to happen, it would

happen to you? NO YES

# MEDICATIONS & ALLERGIES

Do you have any allergies to *ANY* medications: NO YES (Please list **ALL & TYPE** of reaction you experience)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies to the following and list type of reaction you experience: NONE

 □Latex □Food (type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) □Aspirin □Hydrocortisone Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list *ALL* medications (including OTC) you are currently taking □ NONE □ Birth control pills □ Hormones

 □ Others (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently using Aspirin, NSAIDS (Motrin Advil, Aleve), Coumadin or Lovenox? NO YES

Should not be used w/i 1 week of treatment unless Physician reguested. Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used Accutane? NO YES If yes, when did you last use it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Topical (external) Medications or Skin Care Creams are you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What herbal supplements do you use regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plans to have surgery in the next few years? NO YES Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specific to Botox, Juvederm, Sculptra, Chemical Peels, IPL, Pixel, microdermabrasion,**

**Obagi Skin Care Systems, Tretinion, Hydroquinone, or Latisse**

**Do you have any of the following specific allergies? Please circle:**

|  |  |  |
| --- | --- | --- |
|   | Lidocaine/ Novocain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **YES**  | **Not to my Knowledge**   |
|   | Hydroquinone or skin bleaching agents?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **YES**  | **Not to my Knowledge**   |
|   | Hypersensitivity to Latisse® (Bimatoprost)? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES**  | **Not to my Knowledge**   |
|   | Any Botulinum toxin (Botox®) product?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **YES**  | **Not to my Knowledge**   |
|   | Gram-positive bacterial proteins?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **YES**  | **Not to my Knowledge**   |
|   | PLLA (dissolvable sutures), Carboxymethalcellulose, Mannitol? **\_\_\_\_\_\_\_ YES**  | **Not to my Knowledge**   |
|   | Sodium Metabisulfite or Sulfites (found in foods & Rx preservatives)?\_\_ Y**ES**  | **Not to my Knowledge**   |
|   | Do you have a history of Errythema Abigne, (persistent skin rash\_\_\_\_\_\_ **YES** caused by exposure to heat or infrared irritation?)  | **Not to my Knowledge**   |

If you circled “YES” to any of the above, please explain here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Do you presently have or have you had a history of any of the following conditions? Please circle Yes or No

1. Any disease that affects muscles and nerves? Yes / No
2. Amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease]? Yes / No
3. Myasthenia gravis or Lambert-Eaton syndrome? Yes / No
4. Bleeding problems Yes / No
5. Weakness of your forehead muscles, trouble raising your eyebrows? Yes / No
6. Drooping eyelids? (other than natural aging) Yes / No
7. Any other recent change in the way your face normally looks? Yes / No
8. Side effects from any Botulinum toxin product in the past? \_\_\_\_\_\_\_Yes / No
9. Breathing problems, such as asthma or emphysema? Yes / No
10. Swallowing problems? Yes / No
11. Do you form thick or raised scars (keloids) from cuts or burns? Yes / No
12. Hyperpigmentation (darkening of the skin) or Hypo pigmentation (lightening of the skin)

|  |  |
| --- | --- |
|  or marks *after physical trauma*?  | Yes / No  |
| 13. Areas of persistent redness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Yes / No  |
| 14. Are you on immunosuppressive therapy?  | Yes / No  |
| 15. Do you have history of any eye pressure problems?  | Yes / No  |
| 16. Are you using IOP (intraocular pressure) medication  | Yes / No  |
| 17. Intraocular Inflammation or Macular Edema?  | Yes / No  |
| 18. Have a pacemaker or internal defibrillator?  | Yes / No  |
| 19. Herpes infections, bacterial or fungal infections *in the areas to be treated*?  | Yes / No  |
| 20. Have any autoimmune disorders?  | Yes / No  |
| 21. Have had extensive radiation therapy?  | Yes / No  |
| 22. History of epilepsy?  | Yes / No  |
| 23. Scleroderma or other connective tissue disease?  | Yes / No  |
| 24. Are you using medications that make you sensitive to light?  | Yes / No  |
| 25. Are you using preparations containing sulfur, resorcinol, or salicylic acid?  | Yes / No  |
| 26. Do you have a history of anaphylaxis?  | Yes / No  |
| 27. Do you have multiple severe allergies?  | Yes / No  |
| 28. Are you using contraception?  | Yes / No  |
| 29. Pregnant or plan to become pregnant?  | Yes / No  |
| 30. Breast-feeding or plan to breastfeed?  | Yes / No  |

**If you circled “Yes” to any of the above, please explain here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the Aesthetician, therapist, nurse, or doctor of my current medical or health conditions and to update this history. A current medical history is essential for Skin, A medical Spa to execute appropriate treatment procedures.

 **Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Reviewed with patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Use of Photographs for Medical Education, Science or Research**

# Explanation

This consent form authorizes this Provider and individual members of their clinic’s staff to use these photographs for medical education teaching or research. Under no such circumstances will any publications or material bear your name. Your refusal to consent to the use of these photographs for medical education teaching or research will in no way influence your treatment.

# Consent

I understand the photographs taken of me shall be used for medical records and if in the judgment of the medical health care professional, medical research, education or science will be benefited by their use. Such photographs and information relating to my case may be published and republished either separately or in conjunction with each other in professional journals or medial books or used for any other purpose which my health care professional may deem proper in the interest of medical education, knowledge or research.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless Skin, A Medical Spa and its staff from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the following limitation: Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name unless voluntarily disclosed by me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Treatment and Services Cancellation Policy**

If you need to cancel or reschedule your appointment with us, we require a 48 hour notice.

 If you do not give a 48 hour notice or are a “no show” to an appointment in excess of two times, we will require a credit card deposit in order to schedule or reschedule your next appointment with us.

 By signing this consent, you understand our policy and agree to adhere to it to the best of your ability.

**Patient Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**