CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser 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/Mobile Phone (___ _) Work Phone (____) _____

Email Address:_____

Emergency Contact Name and Phone

How did you hear about us?
Were you referred to us by someone?_____
Name of individual so we may thank them: _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, for what:

Are you currently under the care of a dermatologist? Yes No

If yes, for what:

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents Others**:** _____

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe

_____

MEDICATIONS

What oral medications are you presently taking? Birth control pills Hormones

Others (Please list):

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

Have you ever used Accutane? Yes No, If yes, when did you last use it?

What topical medications or creams are you currently using? Retin-A® Others (Please list):

What herbal supplements do you use regularly?

My interest in skincare treatment is primarily: circle those that apply

- HYDRAFACIAL
- BLUE LED THERAPY
- LYMPHATIC DRAINAGE
- DERMAPLANING
- RED LED LIGHT TREATMENT
- LASER HAIR REMOVAL
- SPIDER VEINS
- CHERRY ANGIOMA
- AGE SPOTS / PIGEMENTATION / ROSACEA
- SKIN REJUVENATION / SKIN TIGHTENTING

• Specify your areas of concern (i.e. eyes, forehead, etc.)

_____

_____

MEDICAL INFORMATION:

YES	NO	Medical Information
		Accutane or other similar medication

		Autoimmune disease, HIV, lupus, hepatitis, scleroderma
		Blood thinners – Heparin, Coumadin, Warfarin, Daily Aspirin/NSAID or Vitamin E, etc.
		Breast feeding, pregnancy
		Cancer or post-cancer treatments
		Cardiovascular problems
		Cold sores or fever blisters without pre-medication
		Cortisone or steroid injections
		Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
		Eczema, psoriasis
		Enlarged or painful glands
		Epilepsy
		Facial waxing services w/in 7-14 days
		Heart ailment
		Hypertension/high blood pressure
		Inflammatory conditions
		Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
		Keloids, pigmented scars, icepick scars, new scar tissue
		Laser procedures, chemical peels, dermabrasion, microdermabrasion
		Light sensitive medication
		Medical Information
		Loose, thin, aged skin
		Lymphatic disorder, inflammation of lymph vessels, lymphedema
		Medication, list here:
		Phlebitis, varicose veins
		Recent accident or serious injury
		Recent surgical or dental procedure
		Rosacea, telangiectasia/couperose
		Retin-A, Retinol
		Skin abrasions or lesions
		Stage III or IV acne
		Skin-lightening or bleaching agent
		Sunburn
		Swollen or infected tonsils
		Thyroid conditions
		Type I diabetic
		Under medical care for an existing or suspected condition or disease
		Viral infection, influenza
		Other contraindication at discretion of skincare technician or medical practitioner:

• If you answered **YES** to any of the above questions please explain

_____

_____

CLIENT CONSENT:

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. _ *(initial here)*

2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment.
_____ *(initial here)*

3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen. _____ *(initial here)*

4. I acknowledge that my skin might experience temporary irritation, tightness, or redness which usually dissipates within 72 hours depending on skin sensitivity. _____ *(initial here)*

5. I have disclosed my history of allergies above. _____ *(initial here)*

6. I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions. _____ *(initial here)*

7. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, especially between 10am - 2pm. _____ *(initial here)*

8. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____ *(initial here)*

9. I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment.
_____ *(initial here)*

10. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and/or skincare practitioner during and following the treatment. _____ *(initial here)*

11. I acknowledge that I am not pregnant/lactating. _____ *(initial here)*

12. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____ *(initial here)*

13. I acknowledge that I have answered all questions truthfully and completely. _____ *(initial here)*

14. I release Edge Systems, the _____ (Aesthetician/Doctor), management and staff of _____ (Clinic/Office) from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. _____ *(initial here)*

15. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval. _____ *(initial 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 technician, esthetician, therapist, doctor or nurse 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.

Signature _____ Date _____

Operator Signature _____ Date _____