

Skin Perfections Med Spa

Medical & Personal History

Date: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____

Email Address: _____

How did you hear about our facility?

Living Magazine Phonebook Website KU Other _____

Were you referred by someone? If so, who _____

Skin Type (Fitzpatrick)

Color	Reaction to Sun	Color	Reaction to Sun
<input type="checkbox"/> I Very Pale	Always Burns, Never Tans	<input type="checkbox"/> IV Medium Brown	Minimally Burns, Easily Tans
<input type="checkbox"/> II Fair	Always Burns, Minimally Tans	<input type="checkbox"/> V Dark Brown	Rarely Burns, Tans Very Easily
<input type="checkbox"/> III Medium	Sometimes Burns, Average Ability to Tan	<input type="checkbox"/> VI Black	Never Burns, Profusely Tans

How often do you actively sunbathe or tan? _____

Please check all ethnicities that apply to you:

Caucasian African American Hispanic Asian Indian Other _____

Please list any past or current medical conditions for which you have received treatment:

Please list current medications being taken and reason for each:

List any allergies, including allergies to medications, you have or may have experienced in the past:

Have you ever taken or used any of the following? If so, list date, dosage and any complications:

Retin A/Differin
Renova/Retinoids
Birth Control
Accutane

Immune Deficiency Medications
Hormones/Hormone Therapy
Aspirin Therapy/Blood Thinners
Alpha/Beta Hydroxy Acids

Herbal Supplements
Tetracycline/Minocycline
Doxycycline/Other
Hydroquinone

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Have any of the following conditions ever applied to you? If so, please explain:

Acne	Cold Sores	High Blood Pressure	Skin Cancer / Atypical lesion
Allergies	Contacts	Rosacea	Hyper/hypo pigmentation
Pregnancy	Blood Disorders	Diabetes	Epilepsy / Seizure Disorders
HIV Positive	Bruise Easily	Immune deficiency	Reaction to Sun/Sun Poisoning
Nursing Disorders	Pregnant	Smoking	Predisposition to Keloids
	Hives	Scar Easily	

Are you being treated for any other conditions not listed? If so, please explain:

Have you ever undergone (or have intention of undergoing within the next year) any of the following procedures or surgeries listed below?

Microdermabrasion	Recent Surgery	Laser Resurfacing	Botox/Fillers
Face Lift (full or partial)	Permanent Makeup	Cellulite Treatments	Hair Removal
Reconstructive Surgery	Vein Treatments	Age Management	Chemical Peel
Sun Damage Treatment			

Were there any complications suffered as a result of the procedure or recovery process? Explain.

Is there any other information that may be related to or is pertinent to your treatment? Explain.

Depression/Related Illness	Y N	Ovarian/Uterine Caner	Y N	Diabetes	Y N
Excessive loss of Urine	Y N	Shortness of Breath	Y N	Migraines	Y N
High Blood Pressure	Y N	Blood Transfusion	Y N	Colitis	Y N
Frequent Bladder Infections	Y N	Kidney Infections	Y N	Asthma	Y N
Urinary Frequency	Y N	Thyroids Problems	Y N	Tuberculosis	Y N
Blood/Tarry Stools	Y N	Hepatitis/Jaundice	Y N	Heart	Y N
Change of Bowel Habits	Y N	Bone/Joint Problems	Y N		

FAMILY HISTORY: In your close family history (mother, brother, sister) is there a history of:

Heart attack under age 50	Y N	Diabetes	Y N	Birth Defects	Y N
High Blood Pressure	Y N	Breast Cancer	Y N	Uterine Caner	Y N
Ovarian Cancer	Y N				

SURGICAL HISTORY: List date of all surgeries and name of physician who performed surgery:

Patient Signature: _____ Date: _____

Information and Consent

Your signed consent is required prior to any procedure being performed at Skin Perfections Med Spa. This is for your safety as well as that of your skin care professional's safety. Your signature at the end of this document confirms that your skin care professional has fully explained the procedure you will be undergoing, and any possible, though unlikely, conditions or complications associated with the procedure. **Please initial next to each item number.**

- _____ 1. **Medications & Past Procedures** – I have given a complete list of my medical history. This includes all current or recent medications, prescriptions as well as over-the-counter, with the dates of last dosages. It includes current & previous procedures related to my treatment.
- _____ 2. **Pre & Post Procedure Directions** – I agree to follow all directions given to me by my skin care professional relating to my treatment. This may include temporarily discontinuing retinoid creams, obtaining approvals from other physicians or pharmacist, discontinuing certain forms of hair removal techniques, undergoing antiviral or antibiotic therapy, or following a therapeutic skin care regimen designed by my skin care professional.
- _____ 3. **Cold Sores, HIV, & Herpes Simplex** – I have been candid with my technician about any of these or related conditions. If deemed necessary, I will agree to begin antiviral medications 3 days prior to treatment and follow the full course of the treatment in order to prevent an outbreak of certain conditions.
- _____ 4. **Photosensitive Medications** – If I have taken Accutane® or other photosensitive medications, such as tetracycline, I have provided the technician with the last date of dosage. I understand I must not have laser hair removal if I have taken a photosensitive medication within the last 6 to 12 months.
- _____ 5. **Diabetes, Clotting Disorders, or Blood Thinning Medications** – Due to possible clotting complications and or bruising, I understand that I may not be a candidate for certain procedures or that more treatments may be necessary to reach my desired results. I may be required to provide signed approvals from my physicians before my treatment series begins.
- _____ 6. **Pregnancy & Breast Feeding** – If I am pregnant, breast feeding, or trying to conceive at this time, I may not be a candidate for certain treatments.
- _____ 7. **Birth Control Pills & Hormone Therapy** – I understand that there are certain hormones used in birth control pills and other hormone therapies that may cause varying results from my treatments or certain conditions such as Melasma.
- _____ 8. **Botox, Collagen & Other Injectables** – I have disclosed any cosmetic enhancement procedures I have had/intend to have performed on the treatment area. I understand that some procedures or injectable enhancements may require me to postpone this treatment for a period of 1 week or otherwise as specified.
- _____ 9. **Sun Exposure & Tanning** – I understand that active tanning, whether by the sun or by a tanning bed, will compromise the integrity of my skin, healing time, & final results for some procedures. I have been instructed on the importance of and the proper measures of sun protection by my skin care professional.
- _____ 10. **Moles, Raised Lesions, or any Atypical Lesion** – I understand that moles & any unidentified or abnormal lesions will not be treated. I agree to assess these areas on a regular basis for any changes and seek the advice of a dermatologist if I suspect any malignancy.
- _____ 11. **Results** – I understand that medicine is not an exact science and the results of the cosmetic procedures we perform will vary between individuals. I acknowledge that no guarantee or assurance has been given to me concerning the exact result of any procedure.
- _____ 12. **All sales & procedures are final. There will be no refunds or exchanges on any products or procedures that you purchased.**

Patient Signature: _____ Date: _____

Skin Typing Matrix

Name: _____ Date: _____

Please answer the following questions by circling the number which best describes you.
Your technician will total your score during the consultation.

My Ethnic origin is closet to:	Very Fair (Celtic and Scandinavian) _____ Fair-Skinned Caucasians with light hair & light eyes _____ Pale-Skinned Caucasians with dark hair & dark eyes _____ Olive-skinned Mediterranean, some Asian, some Hispanic _____ Dark-skinned Middle Eastern, Hispanic, Asians, some Africans _____ Very dark skinned African _____
My eye color is:	Light Blue 0 Blue/Green 1 Green/Gray/Golden 2 Hazel/Light Brown 3 Brown 4
My natural hair color At the age of 18 was:	Red 0 Blonde 1 Light Brown 2 Dark Brown 3 Black 4
The color of my skin that is Not normally exposed to sun is:	Pink to reddish 0 Very Pale 1 Pale with a beige tan 2 Light Brown 3 Medium to dark brown 4 Dark brown-black 5
If I go out into the sun for an Hour or so w/o sunscreen and Have not been in the sun for Weeks, my skin will:	Burn, blister and peel 0 Burn, then when burn resolves there is little or no color 1 Burn, but then turns to tan in a few days 2 Gets pink, but then turns tan quickly 3 Just tans 4 Just gets darker 5 My skin color is so dark I can't tell 6
When was the last time the area To be treated was exposed to Natural sunlight, tanning booths Or artificial tanning creams?	Longer than one month ago 0 Within the past month 1 Within the past two weeks 2 Within the past week 3

If your score is:
0-3
4-7
8-11
12-15
16-19
20-24

Your skin type is:
1
2
3
4
5
6

Total Score _____

SKIN HEALTH QUESTIONNAIRE
(CONFIDENTIAL)

Thank you for completing this confidential questionnaire.

This information will allow your skin care professional to provide the optimum products & services.

Printed Name: _____ DOB: _____

Do you Smoke? _____ How often? _____ Live w/ a smoker? _____

Have you been treated for any of the following? (Please Circle)

Acne/Clotting Disorder/High Blood Pressure/Diabetes/Cancer/Cold Sores/Deep Vein Thrombosis

Circle your current level of stress: (least) 1 2 3 4 5 6 7 8 9 10 (most)

Circle your normal level of stress: (least) 1 2 3 4 5 6 7 8 9 10 (most)

How many ounces of water do you drink daily? _____

Do you take vitamin supplements? _____ If so, which ones? _____

Do you exercise? _____ If so, how often? _____

Date of your last sunburn? _____ Do you use tanning beds? _____

Have you ever been under the treatment of a: Dermatologist__ Plastic Surgeon__ Esthetician__

Do you have a home skin care regimen? _____ What products? _____

Are you using a facial sunscreen daily? _____ If not, why? _____

Circle how you feel about the overall quality of your skin:

(poor condition) 1 2 3 4 5 6 7 8 9 10 (fantastic condition)

My skin is: Normal Normal but Oily in T-Zone Dehydrated/Dry Oily Acne/Acne-Prone Rosacea

Please rank the improvement you would like to see in your skin in the next 30 days,

From 1 (the most important) to 6 (the least important):

- ___ Reduction of fine lines
- ___ Reduction of brown spots/ sun damage
- ___ Reduction of acne breakouts/oil skin
- ___ Reduction of redness
- ___ Reduction of acne scars
- ___ Reduction of spider veins (face or legs)

Patient Signature: _____ Date: _____

PATIENT SKIN CARE CONSULTAION

Name: _____ DOB: _____ Date: _____

Patient's Main Concern: _____

Past Skin Care Regimen: _____

Current Skin Care Regimen: _____

(To Be Completed by Clinician)

Condition on Skin: _____

Recommended Skin Care Regimen:

Ageless Anti-Aging

- Cleanser
- Anti-Aging Serum
- Repair Crème
- Masque
- Skin Lightening Serum
- Skin Bleaching Serum
- Skin Bleaching Serum RX
- Eye Lift Crème
- Retinol-A Crème
- Pure Hyaluronic Acid

Vital C Hydrating

- Cleanser
- Anti-Aging Serum
- Masque
- Repair Crème
- A, C, & E Serum

Clear Cell

- Salicylic Cleanser
- Medicated Scrub
- Salicylic Clarifying Tonic
- Medicated Acne Mask
- Medicated Acne Lotion

Sun-Solar Defense

- SPF 30 Oil Free Gel
- SPF 30 Hydrating Crème
- SPF 30 Organic

NeoCutis

- Neo Cutis Bio-Restorative Cream
- Bio-Gel Bio-Restorative Hydrogel
- Journee Bio-Restorative Day Crème
- Lumiere Bio-Restorative Eye Cream
- Hyalis™ Refining Serum

Product Samples Given/Product Purchases Made:

Procedures Recommended

- Laser Hair Reduction
- Microdermabrasion
- Chemical Peel
- OmniLux Light Therapy
- IPL
- Refirme
- T3
- MicroLaser Peel™
- Acoustic Wave Therapy
- Laser Vein Therapy
- ProFractional™
- Botox®
- Juvederm™

Treatments Agreed Upon in Order:

1. _____
2. _____
3. _____
4. _____

OTHER COMMENTS:

Signature of Skin Care Professional: _____ Date: _____

Miles Mahan, M.D. _____ Penny Landers RNC NP _____