

# MedEstheticsRx

# Skin Care History

Please answer the following questions so that we may have a better understanding of your general health and lifestyle, thereby enabling us to accurately analyze and assess your skin care needs.

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Would you like to receive emails of upcoming specials? Yes No

How did you hear of us? \_\_\_\_\_

<p><b>Have you had any of the following?</b></p> <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Botox or Dysport Injections</li> <li>• Skin Cancer</li> <li>• Dermatitis</li> <li>• Keloid Scarring</li> <li>• Laser Resurfacing</li> <li>• Chemical Peels</li> <li>• Hepatitis</li> <li>• Other (please specify below)</li> <li>• _____</li> </ul>	<p><b>Please indicate the conditions in which you want to improve or change?</b></p> <ul style="list-style-type: none"> <li>• Hyperpigmentation (Brown Spots)</li> <li>• Acne</li> <li>• Acne Scarring</li> <li>• Sun Damage</li> <li>• Enlarged Pores</li> <li>• Fine Lines &amp; Wrinkles</li> <li>• Age Spots</li> <li>• Surgical Facial Scar</li> <li>• Other (please specify below)</li> <li>• _____</li> </ul>
<p><b>Are you currently using any of the following?</b></p> <ul style="list-style-type: none"> <li>• Retin A / Renova</li> <li>• Glycolic Acid / Alpha Hydroxy Acid</li> <li>• Accutane (Within One Year)</li> <li>• Topical Vitamin C</li> <li>• Hydroquinone</li> </ul>	<p><b>How is your general health?</b></p> <ul style="list-style-type: none"> <li>• Excellent</li> <li>• Good</li> <li>• Fair</li> <li>• Poor</li> </ul>
<p><b>Have you ever had an allergic reaction to any skin product or cosmetic?</b></p> <p style="text-align: center;">Yes          No</p> <p><b>If yes, please specify...</b></p> <p>_____</p>	<p><b>Do you use a sunscreen or sunblock?</b></p> <p style="text-align: center;">Yes          No</p> <p><b>If yes, please specify which brand...</b></p> <p>_____</p>
<p><b>Do you sunbathe or participate in outdoor activities?</b>    Yes          No</p>	<p><b>Do you presently have or have you ever had acne?</b>    Yes          No</p>
<p><b>Please list all medications you are currently taking:</b></p> <p>_____</p>	<p><b>Have you seen a Dermatologist in the past year?</b></p> <p style="text-align: center;">Yes          No</p>



I voluntarily request that MedEstheticsRx, as deemed necessary, provide me with one or all of the following procedures: Microdermabrasion, Dermaplaning, Chemical Peel, Ultrasound, Growth Factors (Human or Plant Derived). I understand the procedures are not a "cure all" treatment. However, for certain skin conditions, these in-practice procedures can provide significant improvement in the appearance of one's skin. Therefore, it is important that you have a thorough understanding of what these in-practice procedures can and cannot do for your skin condition. In addition, it is imperative that you acknowledge the potential risks associated with in-practice procedures. Please read and initial each statement.

\_\_\_\_ I understand this is NOT a Spa facial treatment. I understand that the in-practice procedure is a medical strength cosmetic skin rejuvenation treatment and that I may need several administrations of the procedure in order to achieve my best results. (Once every 4-6 weeks)

\_\_\_\_ I understand that an at home treatment protocol, used daily, will enhance and maintain the results of in-practice procedures.

\_\_\_\_ I understand that in-practice procedures are administered by medically certified estheticians also licensed by the state of California. All estheticians performing in-practice procedures are supervised and report to a/our physician.

\_\_\_\_ I understand that it is important to strictly follow at home care instructions for optimal results. I will notify MedEstheticsRx if I experience any adverse reactions or side effects that appear to be attributable to my use of home care products and discontinue use of the products until otherwise advised. Opened and/or Used products will receive product credit. Unopened and/or Unused products may receive a full refund within 30 days.

\_\_\_\_ **Most do not experience side effects, however, I understand there may be some degree of discomfort, such as stinging, pinpricking sensations, heat, or tightness of the skin. I may also experience redness, peeling, mild scabbing or increase/decrease in pigmentation, which is usually temporary. Infection is extremely unlikely but may occur. An outbreak of herpes/cold sores may occur in effected individuals.**

(Ask your physician for an anti-viral medication if you are prone to herpes/cold sores.)

\_\_\_\_ If the Dermaplaning phase is administered; hair is expected to grow back blunt ended. New hair WILL NOT appear darker or denser.

\_\_\_\_ I understand that there are no guarantees as to the result of this treatment, due to many variables such as age, condition of my skin, sun damage, smoking, climate, etc. **I understand that I may or may not peel and that each case is individual.**

\_\_\_\_ Prior to this treatment I have been candid in revealing any condition that may have a bearing on this procedure, such as pregnancy, a pace maker, epilepsy, high blood pressure or any type of heart condition; any aforementioned condition will prevent one or all procedures. All patients must disclose the presence of metal implants, inflammation, open wounds, recent facial surgery, allergies, tendency to cold sores, use of Retin A or Accutane.

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\_\_\_\_\_ I understand I will be more sun sensitive and I agree to refrain from tanning either in a tanning booth or outdoors while I am undergoing treatments and during the 14 days following. I will use a sunblock/moisturizer with an SPF minimum of 30.

\_\_\_\_\_ I understand that if I remove my jewelry I will place it in my pocket or purse. MedEstheticsRx is not responsible for lost or misplaced items.

\_\_\_\_\_ I have not received any alcohol or medication prior to signing this consent.

\_\_\_\_\_ I understand that there is a 48 hour cancellation policy. Missed appointments are charged in full. Lateness in excess of 15 minutes may forfeit your appointment.

\_\_\_\_\_ I certify that I have read and understand the above information, that I have been given the opportunity to discuss all my questions and have received satisfactory answers. I hereby consent to the in-practice procedure. This document supersedes any previous written or verbal disclosure.

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<b>Patient Name</b>	<b>Signature</b>	<b>Date</b>
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<b>Witness Name</b>	<b>Signature</b>	<b>Date</b>
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