Loudoun Laser and Medical Spa Medical Form

Today's date_____________

Full name____

Last First Middle

Street address____

City, State, Zip Code____

Home Phone__________________Work__________________Cell______________________

Email______________________Occupation________________Date of Birth______________

Emergency Contact_____________________Relationship__________Phone______________

Primary Care Physician______________________Phone______________________________

How did you hear about us?____

Please specify your Genetic Origin: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐ Mediterranean ☐ Middle Eastern ☐ Native American ☐Other________________

Height____________ weight____________lbs initials_____________

MEDICATIONS

Please list all medications currently or recently taken (prescription drugs, over the counter drugs, vitamins, herbs & supplements)

____

____

1. Are you allergic to any medications?Yes ○ No ○
2. If yes, please list allergic medication and reactions____
3. Do you use or have ever used Adapalene Hydeoxl Acid, AHA, Accutane, Retin-A, Renova, Deferin, Salicylic Acid or any vitamin A derivative products?
4. Have you use Acutane? Date of last use?_____________________

MEDICAL HISTORY

- Acne
- Any active infections
- Arthritis
- Asthma
- Autoimmune disease
- Bleeding disorders
- Bums/skin graft
- Cancer
- Diabetes
- Eczema
- Epilepsy
- Fever blisters/Cold sores
- Filler injections
- G6PD deficiency
- Gold therapy
- Headaches
- Heart problems
- Hepatitis
- Herpes
- High/Low blood pressure
- Hirsutism
- HIV/AIDS
- Hormone imbalance
- Hormone replacement therapy
- Hysterectomy
- Immune disorders
- implants
- Keloid scars
- Kidney/liver disease
- Melasma
- Pacemaker
- Pre-cancerous lesions
- Polycystic ovary diseases
- Poor circulation
- Port-wine stain
- Psoriasis
- Rosacea
- Scar easily
- Seizures
- Skin disease/skin legions
- Skin cancer
- Shingles
- tattoos
- Thyroid disease
- Varicose veins
- Vitiligo
- Warts

5. Do you smoke? ○ Yes ○ No
6. Do you follow a restricted diet? ○ Yes ○ No
7. What is your stress level? ○High ○ Medium ○ Low
8. Do you wear contact lenses? ○ Yes ○ No
9. Have you been exposed to the sun or a sun tanning bed within the last 48 hours? ○Yes ○No
10. Have you ever experienced claustrophobia? ○Yes ○No
11. Do you have any implants in the area to be treated? ○ Yes ○No

12. List any medications or vitamins you are taking daily:____
____

13. Have you ever experienced an allergic reaction to any of the following? ◯Yes ◯No

o Cosmetics	o Food	o Sunscreens
o Fragrance	o Shellfish	o Iodine
o Medicines	o latex	o AHAs
		o Others_____________

14. If yes, please explain:____
15. Does your skin remain discolored after healing from a cut? ◯ Yes ◯ No

Female Clients Only

16. Are you taking any oral contraceptive? ◯Yes ◯No
17. Are you pregnant or trying to become pregnant? ◯ Yes ◯ No
18. Are you breastfeeding? ◯Yes ◯No
19. What is the date of your last cycle?______________
20. Are you experiencing any menopause problems? ◯Yes ◯No
21. Please list any questions or concerns that you have with your skin and/or the reason for your visit:
____
____
____
22. Which skincare and cosmetic products are you currently using?_____________________________
____
____

Always inform us of any changed in your medical history and/or medications as soon as possible. Thank you!

PHOTOGRAPHY CONSENT

I consent for photos to be used for office use. ◯ Yes ◯No

I consent for photos being used for advertising. ◯ Yes ◯No

PATIENT ACKNOWLEDGEMENT

I understand, have read and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client; therefore no guarantee can be given. I also understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Loudoun Laser and Medical Spa, and my esthetician from liability and assume full responsibility thereof.

Client Name____

Client Signature:_______________________________________ Date:____________________________

Client Consultant Signature:______________________________ Date:____________________________

Reviewed by Supervising Physician:________________________ Date:____________________________

UPDATE:

I have reviewed my confidential history form and have no changes to my health and haven't started any new medications.

Client Signature:_______________________________________ Date:____________________________