Client Information and Medical History

Silk Touch Medspa & Laser Center

Pt:

Date of birth:

2014.04

Name_____ Sex M F Date of Birth_____

Cell _____ Phone_____ Emergency Contact Name & Phone_____

Home Address _____ City/State_____ Zip _____

Occupation_____ Circle one: Married Partnered Single

Email_____ (Please print clearly)

How did you hear about us? Client Name_____ Other _____

Desired Treatment:	Interested?		Previously Treated		Previous Adverse reaction to treatments
Laser Hair Removal	yes	no	yes	no	_____
Facial Rejuvenation	yes	no	yes	no	_____
Acne Treatment	yes	no	yes	no	_____
Vein Treatment	yes	no	yes	no	_____
Liposuction	yes	no	yes	no	_____

Other _____

Yes **No** Have you taken **ACCUTANE** in the last 6 months?
Yes **No** Have you ever used a medication that caused a **photosensitivity reaction to sunlight**?
Yes **No** Have you **tanned or used any self tanner in the past 4 weeks**?
Yes **No** Do you have **sensitive skin**? (please describe)_____ _____
Yes **No** Have you ever been diagnosed with a **skin condition** such as **dermatitis or rosacea**? _____
Yes **No** Do you **smoke**? Packs per day ____
Yes **No** Do you **scar** easily?
Yes **No** Have you ever had **cold sores** (oral herpes) or genital herpes?
Yes **No** Do you have any **lesions, sore, moles or tattoos** in the treatment area?
Yes **No** Do you have a **bruising or bleeding** disorder?
Yes **No** Do you take Aspirin, NSAIDs such as Advil, Aleve etc.., Omega III fish oil or flax seed, or other **blood thinners**?
Yes **No** Are you **pregnant or breast feeding**? Or Planning to get pregnant in the next 12 months?
Yes **No** Have you ever been **diagnosed** or treated for a **hormone imbalance**?
Yes **No** Do you now, or have you had a **contagious disease**? (Hepitits, AIDS, HIV, STD, etc.) _____
Yes **No** Do you have a history of autoimmune diease or any condition that may weaken your immune system?
Yes **No** Do you have any neurologic deficits or disorders? _____
Yes **No** Have you been diagnosed or treated for **any emotional or psychiatric problems**? _____
Yes **No** Have you ever had an undesirable reaction or outcome to a skin treatment or aesthetic treatment?

Medical conditions:	**Current Medications:**	**Past Surgeries:** Approx. Year	**Allergies:**

Skin Type (Circle One)
I-II: Very Fair – Fair (Burns Easily)
III: Medium (Tans Gradually)
IV: Moderate Brown (Asian/Hispanic)
V: Very Dark (Dark Hispanic)
VI: Very Dark Brown (African-American)

Hair Color
Grey
Blonde
Brown
Black
Red

Office Use:

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

_____ _____
Physician or PA
Evaluation and Rx for Nonincisive, Noninvasive Cosmetic Treatments. Mayproceed with standing order protocols. Exceptions listed below: