"The Final Touch"

Medical Skin Care Spa

Patient Evaluation

Patient Name: _____ **Age:** ____ **DOB:** ___/___/____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Occupation: _____ **Place of Work:** _____

Marital Status: _____ **Email:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Medical History

Are you currently under the care of a physician for your skin? *Yes/ No*
If yes, why? _____

Do you have any of the following medical conditions?

Cancer__ Diabetes__ High Blood Pressure__ Herpes__

Arthritis__ HIV/AIDS__ Keloid Scarring__ Hepatitis__ Skin Disease/Skin Lesions__

Seizure Disorder__ Hormone Imbalance__ Frequent Cold Sores__

Thyroid Imbalance__ Blood clotting abnormalities__ Any Active Infections__ None of the Above__

Have you seen a dermatologist or other physician for your skin? *Yes/No*
If yes, why? _____

Skin Care History

Have you previously had any of the following?

Chemical Peels? Yes/No
Type of Peel: _____ *Date:* _____

Laser Resurfacing, Dermabrasion, or Microdermabrasion? Yes/No
Type/Depth: _____ *Date:* _____

Facial Surgery? Yes/No
Type: _____ *Date:* _____

Medications/Supplements

Are you taking Accutane? Yes/No

If yes, what is the dosage and frequency? _____

Have you <u>ever</u> taken Accutane? Yes/No

If yes, when was your last dosage? _____

What topical or oral medications do you currently use or have you used in the past?

Retin-A: ____ *Hydroquinone:* ____ *Glycolic Acid:* ____

Tranquilizer: ____ *Birth Control/Hormones:* ____ *Diuretics:* ____ *None of the Above* ____

Please list all oral medications you are currently taking.

_____

Please list all nutritional supplements you are currently taking:

_____

Vascular

Do you have broken capillaries in the following areas? Yes/No If yes, in what areas?

Nose Area: __ *Cheek Area:* __ *Chin Area:* __ *Forehead:* __ *Entire Face:* __

Sensitivity and Free Radical Exposure

Have you <u>ever</u> had a skin reaction to any of the following?

Cosmetics: ____ *Aspirin:* ____ *Sulfur:* ____ *Latex:* ____ *Pineapple or Papaya:* ____

Lavender: ____ *Lemongrass:* ____ *Vitamin E:* ____ *None of the Above* _____

Do you smoke? *Yes/No* *How much?* _____

Do you consume alcohol? Yes/*No* *How much?* _____

Do you have a healthy diet? *Yes/No*

Do you exercise? *Yes/No*

Hormones (Women Only)

Do you have regular periods? *Yes/No*

Are you going through menopause? *Yes/No*

Are you pregnant, trying to be pregnant, or lactating? *Yes/No*

During pregnancy, did you ever get hyper pigmentation or masking? *Yes/No*

Pigmentation: How does your skin tan?

Always Burn (I)	__	*Never Burn (V)*	__
Usually Burn (II)	__	*Never Burn "Black" (VI)*	__
Sometimes Burn (III)	__	*Even Pigmentation*	__
Rarely Burn (IV)	__	*Uneven Pigmentation*	__
Birthmark	__	*Other*	__

Acne

Do you have a history of acne? *Yes/No*

Do you have periodic breakouts? *Yes/No*

How noticeable are your pores? __Not very noticeable __Noticeable __Very noticeable

Do you have any of the following?

Pimples? __ White heads? __ Blackheads? __ Enlarged pores? __ Cysts? __

Facial Wrinkles

Do you have any of the following?

Deep Wrinkles? __ Crow's Feet? __ Fine Lines?__

Skin Type

Does your skin ever flake or feel tight and dry? Yes/No If yes, how often? _____

Is your skin ever shiny a few hours after cleansing? Yes/No If yes, how quickly? _____

How often do you experience blackheads or blemishes? Rarely Often Always

Ability to Heal

Does your skin appear fragile or burn easily? Yes/No

Do you have problems healing from a cut or burn? Yes/No

Do you ever use wax or depilatories on your face? Yes/No If yes, last treatment? _____

Have you ever had a "cold sore"? Yes/No If yes, what was the date of your last cold sore? _____

Sun History and Skin Care Lifestyle

Have you or anyone in your family had skin cancer?

Relation? _____ Where? _____

What percentage of time do you spend in the sun?

Summer: _____ Winter: _____

Do you use sun block daily? *Yes/No*

Have you neglected to wear sun block every day? *Yes/No*

Have you ever visited a tanning salon? *Yes/No*

If yes, what is your last visit? _____

Skin Care Treatments

Are you willing to wear sun block every day? *Yes/No*

Do you wear contact lenses? *Yes/No*

What specific area do you want to treat and/or improve?

Neck__ *Face__* *Chest__* *Back__* *Other__*

How quickly do you want to see your skin improve?

_____

Would you like information regarding any of the following cosmetic services and procedures?

___Products for Acne Control

___Products for Blotchy Skin (freckles, sun damage, pigmentation)

___Botox Treatments for Facial lines

___Filler/Collagen Replacement Therapy for Lines and Wrinkles

___Soft Form Facial Implants for wrinkles and frown lines

___Chemical Peels for Facial Skin Improvement

___Laser Treatment for Wrinkles

___Laser Treatment for Tattoo Removal

___Laser Treatment for Facial and Leg Veins

___Laser Treatment for Birthmark Removal

___Laser Treatment for Stretch Marks

___Laser Treatment for Scars

___Laser Treatment for Brown Spots

___Liposuction for Removal of Unwanted Fat Deposits

___Eyelid Surgery

___Breast Enlargement or Reduction Surgery

___Nose Surgery (Rhinoplasty)

___Ear Surgery

___Abdominal Surgery

I certify that the preceding medical, personal, and skin history statements are true and correct and are for treatment and billing purposes only. I am aware that it is my responsibility to notify the office or medical aesthetician of any changes in the above information. By signing this form in which I have read, I am fully aware of my responsibility.

Patient Signature: _____ Date Signed: ___/___/___

Skin Therapist Signature: _____ Date Signed: ___/___/___

Informed Consent

The La Roche-Posay Biomedic MicroPeel or MicroPeel Plus or Jessner Peel or Microdermabrasion (hereinafter "Clinical Procedures") is not a "cure all" treatment. However, for certain skin conditions, these Clinical Procedures can provide marked improvement in the appearance of one's skin. Therefore, it is very important that you have a thorough understanding of what these Clinical Procedures can and cannot do for your particular skin condition. In addition, it is imperative that you acknowledge the potential risks associated with Clinical Procedures.

Discomfort: This is usually minimal and of short duration.

Swelling: This is very unusual, but if it occurs will be minimal and subsides in a few hours to a few days.

Reddening: A red discoloration may persist anywhere from a few days to several weeks.

Demarcation: Refers to the difference in color, texture, or pigmentation that may occur at the junction between the treated and non-treated areas.

Existing Blemishes: Moles, blood vessels (telangiectasias), freckles and sun spots may become more obvious and darker since layers of dead skin have been removed.

Eye injury: If chemicals get into the eye, scarring and vision disturbances may occur. Protective safety glasses should be worn while chemicals are being used during the Micro Peel, Micro Peel Plus, and Jessner procedure.

Scarring: Is very unusual, but may occur.

Pigmentation: Although extremely rare, temporary and possibly permanent changes in the color of the skin may occur.

Milia: May occur, but will usually disappear quickly.

Infection: Is extremely unlikely, but may occur. An outbreak of herpes may occur if individuals (ask your physicians about an antiviral medication) are prone to cold sores.

Hair Growth: If the derma planning phase of the MicroPeel is administered, hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter the normal hair growth pattern and cause a darker and denser restoration process.

General: Any and all risks and complications that result in additional surgery, hospitalization, or time off work are an expense to you.

Should one or more of the foregoing complications arise, please notify the office immediately. Early detection and treatment may minimize future complications

The foregoing list is not intended to be a complete or exhaustive list of all possible complications, which may arise as a result of Clinical Procedures.

The physician will be glad to detail less likely complications or problems.

The Clinical Procedure has been explained to me in detail by the physician and/or members of the physician's staff.

I understand that the Clinical Procedure is a skin rejuvenation treatment and that I may need several administrations of Clinical Procedures in order to achieve my best results.

I understand that for optimal results, a Home Treatment Program is needed to Enhance the results of Clinical Procedures.

I understand that Clinical Procedures need to be administered/supervised by a physician. It is also my understanding that, in addition to receiving a formal training, any non-physician medical assistant (RN, Cosmetologist, or Aesthetician) who administers Clinical Procedures has had her/his skills reviewed and endorsed by the supervising or attending physician.

I understand that it is extremely important to strictly follow all home care instructions when striving for optimal results.

I understand that if I experience any adverse side effects that appear to be attributed to my use of home care products; I would discontinue use of the products immediately and notify the office.

I certify that I have read and understand ALL of the above.
I have also discussed the same with the Physician and/or Aesthetician.

Patient Signature: _____ Date: _____

I certify that I have discussed ALL of the above with the patient and have offered to answer any questions regarding the Clinical Procedures, and I believe that the patient fully understand the explanations and answers.

Physician/Aesthetician Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Accutane Release

I, _____ (Legal name of Patient), acknowledge that I have not taken the oral pharmaceutical medication Accutane (or its equivalent) within the past twelve months. I understand the potential risks involved with Accutane therapy and the problems that could occur when employed in conjunction with the La Roche-Posay corrective home skin care programs and clinical treatments.

Patient: _____ Date: _____

Physician: _____ Date: _____

Aesthetician: _____ Date: _____