



HEALTH HISTORY

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

PERSONAL INFORMATION

Name _____ Date _____ DOB _____ Age _____

Address _____ Sex: ___ Female ___ Male

City _____ State _____ Zip Code _____

Home Phone _____ Work _____ Mobile _____ Other _____

Email: _____

How did you hear of us? Google Yahoo Dallas Voice Existing Patient Other _____

I AM INTERESTED IN: (Please check all that apply)

- HAIR REMOVAL
- SKIN TIGHTENING
- ROSACEA TREATMENT
- ACNE TREATMENTS
- CELLULITE TREATMENT
- OTHER, PLEASE SPECIFY _____
- SKIN REJUVENATION
- ACNE SCAR TREATMENT
- SUN DAMAGE / AGE SPOTS
- LASER LEG VEIN TREATMENTS
- PHOTOFACIAL
- SKIN CARE ADVICE / PRODUCTS
- MICRODERMABRASION/CHEMICAL PEELS
- FACIAL VEIN TREATMENTS
- TEETH WHITENING
- FAT/VOLUME REDUCTION

DO YOU USE SUNSCREEN YES NO IF YES, SPF # AND BRAND _____

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

- ALWAYS BURN, NEVER TAN
- USUALLY BURN, TAN WITH DIFFICULTY
- SOMETIMES BURN, TAN ABOUT AVERAGE
- ALMOST NEVER BURN, TAN VERY EASILY
- RARELY BURN, TAN EASILY
- NEVER BURN, ALWAYS TAN

MEDICAL HISTORY (Please circle your answer)

ACUTANE	YES	NO	HEPATITIS	YES	NO
ACNE	YES	NO	HIRSUTISM	YES	NO
ALLERGIES (drug or latex)	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS	YES	NO	HIV POSITIVE	YES	NO
AUTOIMMUNE DISORDER	YES	NO	KELOID SCARS (other scars)	YES	NO
BLOOD DISORDERS	YES	NO	KIDNEY DISEASE	YES	NO
CANCER (radiation therapy)	YES	NO	METAL PINS IN BODY	YES	NO
COLD SORES	YES	NO	MELANOMA	YES	NO
CONTACT LENSES	YES	NO	PACEMAKER	YES	NO
DERMATITIS/ECZEMA	YES	NO	RETIN A	YES	NO
DIABETES	YES	NO	PCOS (polycystic ovarian)	YES	NO
EPILEPSY	YES	NO	SKIN PIGMENTATION	YES	NO
GENETIAL HERPES	YES	NO	STD'S	YES	NO
HORMONAL IMBALANCE	YES	NO	Steroid or Hormonal Therapy	YES	NO
HEART CONDITION	YES	NO	SHINGLES	YES	NO
HEMOPHILIA	YES	NO	VITILIGO	YES	NO

Please Initial _____
Please fill out other side.

ADDITIONAL QUESTIONS:

1. ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? **YES NO** IF YES, PLEASE SPECIFY.

2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, OR MEDICAL PATCHES? **YES NO** IF YES, PLEASE SPECIFY.

3. DO YOU HAVE ANY ALLERGIES? **YES NO** IF YES, PLEASE SPECIFY.

4. HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? **YES NO** IF YES, PLEASE SPECIFY.

5. HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? **YES NO** IF YES, PLEASE SPECIFY WHEN.

6. HAVE YOU EVER HAD A CHEMICAL PEEL? **YES NO** IF YES, PLEASE SPECIFY.

7. HAVE YOU HAD ANY LASER TREATMENTS? **YES NO** IF YES, PLEASE SPECIFY.

8. WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

9. DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? **YES NO** IF YES, PLEASE SPECIFY.

10. DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? **YES NO** IF YES, PLEASE SPECIFY.

11. DO YOU HAVE A PACEMAKER? **YES NO**

12. HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)? **YES NO** IF YES, PLEASE SPECIFY.

13. DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? **YES NO** IF SO, THEN HOW OFTEN?

14. HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS) **YES NO**

15. ARE YOU CURRENTLY PREGNANT OR TRYING TO GET PREGNANT? **YES NO YOU MUST INFORM US IF YOU BECOME PREGNANT DURING TREATMENTS.**

16. HAVE YOU HAD RESTYLANE, PERLANE, HYLAFORM OR BOTOX INJECTIONS IN THE AREA TO BE TREATED? **YES NO** IF YES, PLEASE SPECIFY.

17. DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES? **YES NO** IF YES, PLEASE SPECIFY.

How soon would you like to begin treatments? Very Soon Near Future Today if Possible

Please sign below to indicate all the information on this for is accurate and complete.

Signature _____ Date _____

Patient Name: _____

Procedure: Microdermabrasion/ Skin Rejuvenation/Chemical Peel

I hereby authorize and direct any associates or assistants of Advanced Skin Fitness to perform Microdermabrasion/ Skin Rejuvenation on me. **Multiple treatments** will be required to achieve cosmetically acceptable results. In rare cases, patients may not experience any improvement in the skin even with multiple Microdermabrasion treatments. I specifically acknowledge that no guarantees or warranties have been made concerning the results of the procedure.

The following points have been discussed with me and I understand:
(please initial each statement)

_____ Possible complications or risks involved with Microdermabrasion include, but are not limited to scarring, scabbing, and long-term pigmentary changes (hypopigmentation or hyperpigmentation.)

_____ I understand that the use of an acid following Microdermabrasion will increase the peel I receive from the treatment and increase my chance of scabbing following my treatment. Healing time will be increased to up to 14 days.

_____ I understand that I must avoid wearing ordinary make-up for at least 24 hours after a treatment.

_____ I understand that in certain cases, a striping in criss-cross directions may appear for a few days after treatment. This is normal and will disappear as the skin heals. Exercise and extreme heat from steam rooms and saunas will increase the appearance of these lines temporarily until the skin heals as well as cigarette smoking, caffeine, aspirin, and other blood thinning medications.

_____ I understand that immediately following the Microdermabrasion, the treated area will appear as a red discoloration and have edema (swelling), and possibly blood spotting. The redness (erythema) and discoloration may take up to 10 days to heal. The treated area will feel like a sunburn or windburn for a few hours after the treatment.

_____ My skin care specialist has answered any questions I have regarding my aftercare. I acknowledge my obligations to closely follow the after care instructions and visit my skin care specialist for a post peel treatment if specified.

_____ I am aware and acknowledge that there is a rare possibility of an allergic reaction. I have discussed thoroughly with my skin care specialist any such reactions and understand them. I am willing to forego a patch test but understand there could be an allergic response.

_____ I have been advised that my treatment is a noninvasive, epidermal exfoliation consisting of Salicylic Acid, Lactic Acid, Glycolic Acid, Resorcinol, TCA, or Red Wine Vinegar Acid. These ingredients stimulate the skin to generate new skin cells and new collagen formation and increase the blood circulation and flow to the skin. It does not replace deep chemical peels, laser resurfacing, or plastic surgery.

_____ I acknowledge that during application I will notice a warm sensation and the skin may tingle, sting, or burn. Immediately after the peel, my face may appear frosted or sunburned, and by day two, the skin may darken in color, feel tighter, and be more sensitive. Beginning days two through seven, the skin will peel. I am not to pick or peel the old skin. Pulling or picking skin may lead to infection (which will require treatment with topical antibiotic) or surface scarring. I may experience some breaking out after a peel.

_____ **Tanning from the sun and artificial tanning devices such as tanning beds must be avoided for 14 days after the treatment.** I understand that it is my responsibility to avoid the sun and to let my technician know if I have received any tan throughout the course of my treatment. Swimming should also be avoided for 14 days after the treatment.

_____ I understand that I must use a full spectrum sunblock with a minimum SPF 25 daily. A non-chemical sunblock such as transparent zinc oxide is less irritating to sensitive skin.

_____ I acknowledge that I have not been on Accutane during the past six months. I acknowledge that I have not been using Retin A or Renova for the past two weeks. I will also avoid the use of Retin A, Renova, alpha or beta hydroxyl type products and all forms of scrubs for at least 14 days, or until sensitivity has subsided.

_____ I acknowledge that if I am prone to cold sores (herpes), I may need a prescription from my physician prior to having a peel. I am aware the treatment could bring about cold sores.

_____ I understand that anytime the skin barrier is broken, there is a small risk of bacterial or viral infection. I will contact Advanced Skin Fitness immediately if I suspect infection.

_____ I acknowledge that I am not aspirin sensitive or if I am I have discussed this with my skin care specialist and understand there could be a reaction.

Patient or legal guardian signature and date _____

Witness signature and date _____



Credit Card Charge Authorization Agreement

We request the courtesy of a 24 hour notice in the event an appointment needs to be cancelled or rescheduled. A \$75 no show fee for facial treatments and a \$100 no show fee for laser treatments will apply in the event advanced cancellation notice is not given. Appointments booked same day of service will be assessed a no show fee should cancellation become necessary. For treatments that are pre-paid, the pre-paid treatment will be forfeited without 24 hour notice of cancellation. Thank you for your cooperation.

I, _____,

hereby authorize Advanced Skin Fitness to charge my credit card used for my treatments in the amount of \$75 for a missed facial treatment or \$100 for a missed laser treatment.

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback Advanced Skin Fitness, as long as I receive the services that are entitled to me and guidelines are followed for my rescheduling and cancellation of appointments. Twenty-four hour notice is required for all rescheduling and cancellations.

Name On Card: _____

Signature: _____

Credit Card Billing Address: _____

City, State, Zip: _____

Telephone: (____) _____

Date: ____/____/____