Medical Aesthetics and Laser — Medical History Form

Name: ______________________ Birth Date: ______________ Age: ______________

Address: ______________________ Sex: M / F

City: ______________________ State: ______________ Zip Code: ______________

Home: ______________ Cell: ______________ Work: ______________

Email: ______________________ Employer: ______________________

Emergency Contact: ______________________ Telephone: ______________________

How did you hear about our practice? ______________________

Please put a check mark next to the items that are cosmetically displeasing to you:

_______ Acne Troubles
_______ Wrinkles
_______ Sun Damage
_______ Cellulite or fat pockets
_______ Skin Texture and Toning
_______ Sagging Skin
_______ Shaving Bumps
_______ Brown Spots
_______ Rosacea
_______ Broken Capillaries
_______ Spider Veins
_______ Chin Fullness

Please put a check mark next to any past or current medical conditions:

_______ Lupus of other auto-immune disorder
_______ Dark Spots after pregnancy or skin injury
_______ Accutane treatments with in the last year
_______ Tetracycline treatments with in the last month
_______ Keloid or very thick scarring
_______ Blepharolplasty (eyelid surgery)
_______ Pulmonary embolism/blood clot
_______ Leg Ulcer or Phlebitis
_______ Blood thining medications
_______ Coumadin or other anti-clotting agents
_______ Rheumatoid Arthritis "Gold" Therapy
_______ Abnormal Heart Conditions
_______ Fainting Spells / Dizziness
_______ Cancer
_______ Do you have any Implantable Devices?
_______ Cold agglutinin disease
_______ Diabetes
_______ Epilepsy
_______ Scars that turn white or brown
_______ Cystic Acne
_______ HIV/AIDS
_______ Hepatitis
_______ Psoriasis or Vitiligo
_______ Herpes Simplex or fever blisters
_______ Hirsutism
_______ Transplant/Anti-rejection Drugs
_______ Bleeding abnormalities
_______ High or Low Blood Pressure
_______ Circulatory Problems
_______ Chemotherapy/Radiation Treatments
_______ Cryoglobulinemia
_______ Paroxysmal cold hemoglobinuria

Are you pregnant or think that you may be pregnant? ______________________

Are you currently breast feeding? ______________________

List any drug, makeup, skin, **soy** or other food allergies: ______________________

____

Do you get pigment or brown spots from an injury, insect bite or cut? ______________

(please turn the page over)

Medical Aesthetics and Laser *Continued*

Have you had any recent chemical peels, dermabrasion, laser procedures or plastic surgery? ____________________

What skin care and makeup products do you use for your skin care? ____________________

Are you currently taking Asprin or ibuprofen? ____________________

When were you last exposed to the sun, including tanning booths? ____________________

Do you use a self tanner? ____________________ If so, when did you last apply it? ____________________

Have you tweezed, waxed or had any electolysis treatments done within the last 4 weeks? ____________________

Are you currently taking any prescription acne medications or having any acne therapies done? ____________________

Please list all medications and herbal supplements that you are currently taking: ____________________

What would you like to discuss in greater detail today with your physician? ____________________

Thank you for choosing Medical Aesthetics and Laser!

Client's Signature ____________________ Today's Date ____________________

I hereby authorize Medical Aesthetics and Laser, and its employees, to take and use pictures for the purpose of: Proof of results and Medical Aesthetics and Laser marketing.

Client's Signature ____________________ Today's Date ____________________

Medical Aesthetics and Laser
8850 Six Pines Dr., Suite 110, The Woodlands, TX 77380

Fitzpatrick Skin Type

Please complete the following questions by circling the number which best describes you. Your physician will total the score during the consultation.

Eye Color

0. Light Colors
1. Blue, grey or green
2. Dark
3. Brown
4. Black

Natural hair color at age 18 was:

0. Sandy Red
1. Blond
2. Chestnut or dark blond
3. Brown
4. Black

Your Skin Color (unexposed areas)

0. Reddish
1. Pale
2. Beige or olive
3. Brown
4. Dark Brown

Freckles (unexposed areas)

0. Many
1. Several
2. Few
3. Rare
4. None

If you stay in the sun too long?

0. Painful blisters, peeling
1. Mild blisters, peeling
2. Burn, mild peeling
3. Rare
4. No burning

Do you turn brown?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

How brown do you get?

0. Never
1. Light tan
2. Medium tan
3. Dark tan
4. Deep dark

Is your face sensitive to the sun?

0. Very sensitive
1. Sensitive
2. Sometimes
3. Resistant
4. Never have a problem

How often do you tan?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

When was your last tan?

0. +3 months ago
1. 2-3 months ago
2. 1-2 months ago
3. Weeks ago
4. Days

If your score is:	Your skin type is:
0 thru 6	I
7 thru 13	II
14 thru 20	III
21 thru 27	IV
28 thru 34	V
35+	VI

Notes:

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HIPAA Release Form

Client Name ________________________________ **Date of Birth** ______________

Release of Information

□ I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

- □ Spouse________________________________
- □ Child (ren) ______________________________
- □ Other__________________________________

□ Information is not to be released to anyone.

This ***Release if Information*** will remain in effect until terminated by me in writing.

Messages

Please call □ Home □ Work □ Cell

If unable to reach me:

□ You may leave a detailed message

□ Please leave a message asking me to return your call

□ ____

The best time to reach me is (day) ___________ between (time) ________

Signed: __________________________________ **Date:** ____/_____/_____

Witness: _________________________________ **Date:** ____/_____/_____

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Cancellation Policy

Cancellation/ Rescheduling of an Appointment

Please contact Medical Aesthetics and Laser at (281) 419-2220 **24 hours** prior to your scheduled appointment date and time to avoid cancellation fees.

Failure to cancel within the required time will result in a fee of **$25.00** being charged to the credit card on file. A ***No Show*** is considered failure to cancel or failure to show for a scheduled appointment, a fee of **$35.00** will be applied to the credit card on file.

New Clients

If a new client ***fails to cancel or reschedule*** their appointment time within the **24 hour** time frame they will forfeit **ALL** limited –time pricing offers, monthly special promotions, discounts or coupons.

We reserve the right to refuse appointments to any client who has demonstrated disregard of our cancellation policy.

I understand the cancellation policy and agree to its terms.

Client Signature ______________________________ **Date:** ____/____/_____
Client Name (Please Print) ____

Debit/ Credit Card Authorization

Cardholders Name (as it appears on card) ______________________________

Credit Card Number (list all numbers) _____________-___________-_____________

Expiration Date ____________________ CVV* ___________
*CVV is the last 3 digits on the back of your card. For AMEX it's the 4-digit code on the front side.

[ ] Master Card [ ] Visa [ ] American Express [ ] Discover

[ ] Check box if same as Home Address

Credit Card Billing Address ____

City _________________________ State ____________Zip Code ______________

I agree to be charged in the amount indicated above via debit/ credit card if I fail to follow the cancelation policy as stated by terms set by Medical Aesthetics and Laser.

Cardholders Signature ________________________ **Date:** ____/____/_____