The Med Spa @ Lake Norman Ob/Gyn

Your Place for Skin Health & Wellness

PERSONAL PROFILE & HEALTH HISTORY FORM

Name: _____Home Phone: _____ Date: _____

Address: _____Cell Phone: _____Mobile Carrier_____

City/State/Zip: _____

Date of Birth: ____/____/____ Age: _____ Gender: M ___ F ___ Occupation: _____

Email Address: _____Can we Text and/or Email Confirmations Yes_____No_____

Spouse/Other Email Address for Valentine/Mother's Day, Christmas or Special Events_____

To ensure the safety and effectiveness of your Med Spa treatment program, please complete the medical history questionnaire below.

1. Are you currently pregnant? Yes ____ No ____
2. Are you currently breastfeeding? Yes ____ No ____
3. Since your family background affects your skin and its response to the treatment, please specify by circling your ethnic origin: Caucasian African American Hispanic Asian Native American Middle Eastern Mediterranean Other
4. Which skin areas would you like to consider for treatment?

   _____

5. Medications

   If you are currently taking any medications, including prescription, over-the-counter, vitamins or supplements, please list them:

   _____

6. Allergies

   If you are allergic to any medications, please list them along with your reactions:

   _____

7. Medical History

   Please check all that apply:

☐ Acne	☐ High Blood Pressure	☐ Port-Wine Stain
☐ Bleeding	☐ Implants	☐ Psoriasis
☐ Disorders	☐ Kaposi's Sarcoma	☐ Shingles
☐ Burns or Skin Grafts	☐ Keloid Scars	☐ Skin Cancer
☐ Diabetes	☐ Lupus	☐ Tattoos
☐ Endocrine Disorders	☐ Permanent Makeup	☐ Herpes
☐ Epilepsy	☐ Pregnancy	☐ Vitiligo

☐ Gold Therapy ☐ Ovarian Disease
☐ Heart Disease

If the answer to any of the following questions is yes, please provide details in the spaces provided.

1. Are you currently being treated for any medical conditions? Yes No

   Explain: _____

2. Have you used Accutane or any other photosensitive drug in the last 12 months? Yes No

   How recently? _____

3. Do you have any active skin diseases or infection in the area to be treated? Yes No
4. Do you have any skin allergies? Yes No
5. Are you allergic to latex or topical numbing agents? Yes No
6. Are you currently using products which contain Glycolic, Salicylic, Lactic acid, Retin A or AHA? Yes No
7. Have you had a chemical peel or facial within the last week? Yes No
8. What products are you currently using on your skin?

   Describe: _____

9. Have you had any permanent cosmetic tattooing in the area to be treated? Yes No
10. Do you have any metal or other implants? Yes No

    Where? _____

11. Have you had any surgical procedure performed in the area to be treated in the last six months? Yes No
12. Describe: _____
13. Are there any moles in the area to be treated? Yes No
14. Are you currently using or have you used a **tanning bed** or self tanning cream, within the last month? Yes No
15. Have you been excessively exposed to the sun within the last four to six weeks? Yes No
16. Have you waxed or received another form of hair reduction in the last month? Yes No
17. How did you hear about The Med Spa? _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant explained the treatment and answered any questions I had.

Signature of Client: _____ Date: _____

Signature of Consultant: _____ Date: _____

Appointment Cancellation/No Show Policy

Due to the increase of late cancellations and no shows the Med Spa is implementing the following policy:

Effective June 1st 2018 any client who fails to show or cancels an appointment less than 24 hours will be charged $25 using their credit card on file.

A second occurrence the client will be charged $50, using their credit card on file.

A third occurrence the client will be charged the cost of the treatment, using their credit card on file.

I have read and understand the Cancellation/No Show Policy and agree to the terms.

Signature:_____ Date:_____

We strive to give you the best service at the very lowest cost and these empty appointments are having a negative effect on our business.

The Med Spa Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, electrolysis, facial toning, body treatments, laser treatments, IPL treatments, vein treatments, brown spot removal, micro needling, waxing, teeth whitening, facial and body peeling, dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness blistering, nerve damage, scaring, infection and change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even through precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on individual basis sand that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend and hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

X _____ Date: _____
Client Signature

_____
Printed Name

MY SPECIFIC CONCERNS AND INTERESTS

(Please check all that apply and indicate any prior treatments in space provided.)

Concerns	List any prior treatment and approximate date(s): (Accutane, Botox, Peels, IPL, Lasers, Surgery/ etc.)
☐ Dry or Oily Skin	
☐ Skin discoloration	
☐ Brown Spots	
☐ Acne	I have used Accutane: YES NO Last Dose:
☐ Rosacea	
☐ Fine Wrinkles	
☐ Deep Wrinkle	
☐ Lip Lines	
☐ Thin Lips	
☐ Nasolabial Creases	
☐ Marionette Lines	
☐ Loose Skin	
☐ Aging Hands	
☐ Excessive Sweating	
☐ Facial/Body Hair	
☐ Leg Veins	
☐ Facial Veins	
☐ Toenail Fungus	
☐ Body Contouring	
☐ Other	
☐ Other	
☐ Not Certain	