Skin Mechanixx Medical History

Date: _____

Personal Information

Name:_____ Date of Birth:_____

Address: _____ City:_____ State:_____ Zip :_____

Phone Number: _____ Email: _____

Occupation: _____ Work Number: _____

Primary Care Physician: _____ Number:_____

How did you hear about us: _____

What is your genetic origin?:

____ African-American _____ Asian ____ Caucasian ____ Hispanic

____ Mediterranean _____ Middle Eastern ____ Native American _____ Other

Females Only

Are you pregnant?___ Yes___No Are you breastfeeding?___Yes___No

Are you planning on a pregnancy during the course of your treatment? _____

Medical Questions: (Please inform us at any time during your treatment if any of this changes)

List all medications you are currently taking. Please include all prescriptions, over-the-counter drugs, herbs, vitamins, and supplements: _____

_____

Are you being treated for any medical conditions? ___Yes___No If so, what?:_____

Have you ever seen a physician for your skin? ___Yes___No If so, what? _____

Please list any recent surgeries with location and a date:_____

Do you have any active skin diseases or infections in the areas to be treated? ___Yes___No

Do you have skin allergies? ___Yes___No Do you have overly sensitive skin? ___Yes___No

Have you ever had skin cancer or precancerous lesions? ___Yes___No

Do you have permanent cosmetics or tattoos on/near the treatment area? ___Yes___No

Have you ever had Psoriasis/Eczema in the area to be treated? ___Yes___No

Does your skin scar or discolor (hyperpigment) easily when injured? ___Yes___No

Have you ever had a keloid scar or a tendency to keloid scar? ___Yes ___No

Are you allergic to latex, cryogen, lidocaine, or any lotions or creams? ___Yes___No

Have you had other laser treatments? ___Yes___No

If so what were the results:_____

Have you used or are you currently using Accutane? ___Yes___No How long have you been off? ____

Are you using Retin-A, Renova, Differin, or Tazorac? ___Yes___No Concentration: _____%

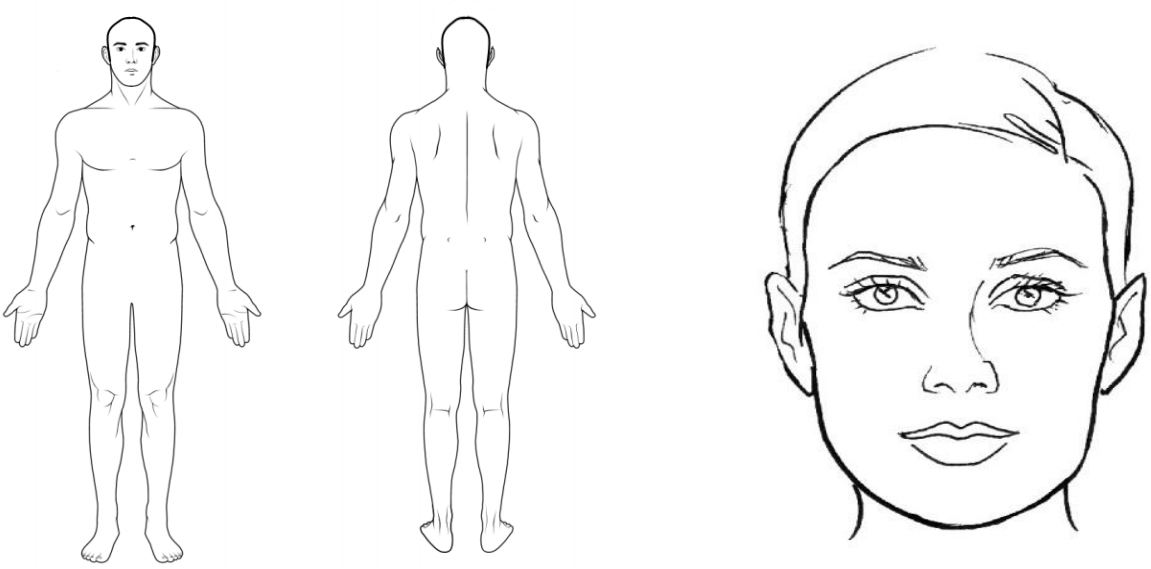
When was the last time you used a chemical peel, AHA, or glycolic? _____

Have you tanned recently (tanning bed or direct sun)? ___Yes ___No Date of last sun exposure:_____

Do you smoke: ___Yes___No Do you use sunscreen? ___Yes___No SPF_____

Do you wax the areas to be treated? ___Yes___No (areas for laser hair removal can't be waxed)

Areas you are interested in treating:



I _____ have filled out this consultation sheet truthfully and I understand its content and purpose. I also understand that if this is not accurate or I don't disclose all information to the clinic of any changes the treatment could cause harm to my skin. I understand that no warranty or guarantee has been made to me regarding the effectiveness of these treatments. In very rare cases treated areas may peel or flake off, burn, discolor, bruise or the initial skin issues may present themselves again in the future. I do know that Skin Mechanixx takes every precaution to make sure that all treatments go smoothly without negative results. In the event of an issue I will hold Skin Mechanixx harmless. By signing this statement, I am making an informed decision and giving my permission to have laser treatment(s) or other skin care treatments performed and have informed Skin Mechanixx, in writing, of any and all medical conditions and disclosed my medical history fully and truthfully. Furthermore, I am stating that all questions regarding this procedure have been answered to my satisfaction.

_____

Client Signature and date

_____

Laser Technician Signature and date