



HEALTH HISTORY INFORMATION

Name: _____ Today's Date: _____
Last First MI

Street address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ Sex: Female Male

Home Phone: _____ Cell Phone: _____

Leave messages at: Home Cell Other: _____

I consent to be reminded of my appointments via text message. (Cell phone required) Yes No

Email address: _____

I consent to this email address being added to the MedSpa at Hendrick email newsletter, where I will get information on specials and promotions. Yes No

Occupation: _____

Primary Care Physician/phone number: _____

In case of Emergency, who should be notified? (name and phone)

Unless otherwise indicated, we have permission to communicate changes in your health status, including surgery, to other physicians participating in your care. Yes, may notify No, please do not notify.

Do you have any major medical problems, serious illness? Yes No If so, please list:

Please list all prior surgical procedures and dates performed:

Please list all injectable procedures (Botox, Juvederm, Restylane, Collagen, etc) and dates performed:

MEDICAL HISTORY

Do you have a pacemaker or defibrillator? Yes No

Do you suffer from "photosensitivity" (extreme sensitivity to sunlight)? Yes No

Do you have a history of easy/excessive Hyperpigmentation? Yes No

Do you form keloid scars? Yes No

Do you suffer from seizures? Yes No

Do you have any metal implants? Yes No

Do you wear contact lenses? Yes No

Have you taken Accutane, Retin A or Renova in the past 12 months? Yes No

Are you currently taking Coumadin (Warfarin) or other blood thinners? Yes No

Do you require antibiotics before procedures such as dental cleanings? Yes No

Do you smoke? Yes No If yes packs per day? _____

Do you drink alcohol? Yes No If yes quantity per week? _____

Have you ever had an adverse reaction to laser or cosmetic treatments? Yes No

If so, please list: _____

Are you allergic to any medications? Yes No

If so, please list: _____

Do you have any other allergies? Yes No

If so, please list: _____

Do you take any of the following (please check all that apply and/or list additional medications):

- | | |
|--|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Hormones/contraceptives |
| <input type="checkbox"/> Anti-coagulants | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> NSAIDS |
| <input type="checkbox"/> Appetite depressants | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Aspirin or Ibuprofen | <input type="checkbox"/> Thyroid Medication |
| <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Cortisone or steroids | <input type="checkbox"/> OTHER _____ |

Are you taking herbal preparations or vitamins (St. John's Wort, Vitamin E, etc.)? Yes No

Are you or might you be pregnant? Yes No

Are you trying to become pregnant? Yes No

Are you nursing? Yes No

Have you ever had any problems with any of the following anesthetics? If so, please specify.

Block (e.g. dental): Ineffective / Heart palpitations / Systemic reaction/ Other _____

Local: Ineffective / Heart palpitations / Systemic reaction / Other _____

Topical: Ineffective / Heart palpitations / Systemic reaction / Other _____

Have you ever had or do you have any of the following (please check all that apply):

Active Infection

Hormonal Imbalance

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Insomnia / Sleeping Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Injury |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Muscle Pain / Spasms |
| <input type="checkbox"/> Circulation Problems/Blood Clots | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Cold Sores / Shingles | <input type="checkbox"/> Permanent Makeup / Tattoo |
| <input type="checkbox"/> Collagen Disorder | <input type="checkbox"/> Pigmentation Disorders |
| <input type="checkbox"/> Diabetes (Type) | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Endocrine / Hormonal Issues | <input type="checkbox"/> Scleroderm |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Sensitive Teeth |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin Injury |
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Unusual Moles |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Vision Deficits |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> OTHER _____ |

SKIN CARE HISTORY AND CONCERNS

Please list any products that irritate your skin:

Have you had unprotected sun exposure or been in a tanning booth in the *last 2 weeks*?

Yes No

Do you use self tanners? Yes No If yes, when was last application? _____

Are you planning a vacation in the sun in the next 3-6 months? Yes No

Have you used any of the following hair removal methods in the *past 6 weeks*?:

Shaving Waxing Electrolysis Plucking/Tweezing Stringing Depilatories

Please indicate your current skin care products/regimen:

Therapist/Provider Reviewed (sign) _____ Date _____



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.)
<input type="checkbox"/> Dry or Oily Skin	
<input type="checkbox"/> Skin discoloration	
<input type="checkbox"/> Brown Spots	
<input type="checkbox"/> Acne	I have used Accutane: <input type="checkbox"/> YES <input type="checkbox"/> NO Last Dose:_____
<input type="checkbox"/> Rosacea	
<input type="checkbox"/> Fine Wrinkles	
<input type="checkbox"/> Deep Wrinkles	
<input type="checkbox"/> Lip Lines	
<input type="checkbox"/> Thin Lips	
<input type="checkbox"/> Nasolabial Creases	
<input type="checkbox"/> Marionette Lines	
<input type="checkbox"/> Loose Skin	
<input type="checkbox"/> Aging Hands	
<input type="checkbox"/> Excessive Sweating	
<input type="checkbox"/> Facial/Body Hair	
<input type="checkbox"/> Scars	
<input type="checkbox"/> Facial Veins	
<input type="checkbox"/> Leg Veins	
<input type="checkbox"/> Not Certain	
<input type="checkbox"/> Toenail Fungus	
<input type="checkbox"/> CoolSculpting/body contouring	
<input type="checkbox"/> Other	
<input type="checkbox"/> Other	

Client Signature : _____ **Date:** _____

Provider Signature: _____ **Date:** _____



SKIN TYPING FORM

Patients Name: _____

Date: _____

(Please circle what applies to the best of your knowledge)

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray Green	Blue, Gray	Green	Brown	Brownish Black
What is the natural color of your hair	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin (non exposed areas)?	Reddish	Very pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	Never	Hardly ever	Sometimes	Often	Always
Did you expose the area to be treated to the sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago *



Below to be completed by the MedSpa at Hendrick Staff

Total score:

***Patient may not be eligible for treatment until at least 2 weeks after exposure.**

Patients Name: _____ Date: _____

Skin Type Score	Fitzpatrick Skin Type	Typical Ethnic back ground
0-7	I	Irish, English, Scottish
8-16	II	Irish, English, Scottish
17-25	III	Dark Caucasian, light Asian
25-30	IV	Hispanic, Asian, Native American, Mediterranean, Light Middle Eastern,
30-35	V	Latin, Islander, Dark Middle Eastern, Light African American,
Over 35	VI	Dark African American

Fitzpatrick Skin Type: _____ Clinical Skin Type: _____

Treatment Skin Type should be the highest skin type calculated for the patient by either Fitzpatrick or Clinical observation.

Treatment Skin Type:

Comments: _____

Consultant: _____ Signature: _____ Date: _____

Provider: _____ Signature: _____ Date: _____



ACKNOWLEDGEMENT OF PRACTICE POLICIES

I understand that I will receive traditional spa or cosmetic medical treatment from the MedSpa at Hendrick. Some of the various treatments the MedSpa at Hendrick provides include: massage therapy; facials; waxing; chemical peels; microdermabrasion; laser hair removal; photorejuvenation/BBL; skin resurfacing; skin tightening; CoolSculpting; Botox® Cosmetic/Xeomin injections and filler injections. I understand that depending on the treatment I select, I will be required to sign an informed consent specific to that treatment. _____ **(Please Initial)**.

I am fully aware that my condition is solely of a cosmetic nature and that the decision to proceed is based on my expressed desire to do so: _____ **(Please Initial)**.

Payment Policy

I understand that my treatments at the MedSpa at Hendrick require payment and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by the MedSpa at Hendrick. For cosmetic medical procedures, I understand that the services often require more than one session for best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There is no guarantee of refunds on treatments paid in advance. Any refunds will be determined on a case by case basis after appropriate management approval. I further understand that the services offered by the MedSpa at Hendrick are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, check or most major credit cards. _____ **(Please Initial)**.

Cancellation, Late and Children in facility Policy

I am aware that the MedSpa at Hendrick **requires 24 hours notice of a cancellation** and that it is my responsibility to provide timely notice by calling the MedSpa at Hendrick. **I agree to pay a \$25.00 fee if I fail to give the required 24 hours notice.** If I have prepaid my treatment session or sessions, I understand that I may forfeit one of my future sessions if I do not provide the MedSpa at Hendrick with the required 24 hours notice. _____ **(Please Initial)**.

The MedSpa at Hendrick asks that I arrive **15 minutes prior** to each of my scheduled appointment time(s) so that all appointments can run both efficiently and timely. **Late arrivals may result in a reduction of treatment time or appointment being rescheduled, along with a cancellation fee of \$25.00 if appointment has to be rescheduled.** _____ **(Please Initial)**.

I understand that children are **not** allowed in the facility or treatment rooms, and bringing them will forfeit my appointment. This is for the safety of the children and the courtesy to other guests. _____ **(Please Initial)**.

Return Policy

All sales of skin care and makeup products are final. Unopened products may be returned with a receipt for a credit within 30 days. _____ **(Please Initial)**

Disclaimer

I understand that all medical cosmetic treatments are provided exclusively by the MedSpa at Hendrick. I will not hold the MedSpa at Hendrick, its owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that the MedSpa at Hendrick cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion: _____ **(Please Initial)**.

I understand that even with the best laser and the highest trained technicians, as high as 10-15% of patients will not have a desired response/outcome to treatments. _____ **(Please Initial)**.

Privacy

I have received a copy of the Hendrick Medical Center Notice of Privacy Practices. _____ **(Please Initial)**.

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent:

Print Patient Name: _____ **Patient Signature:** _____ **Date:** _____

I have explained the above statements to the client and answered all questions.

Staff Name: _____ **Staff Signature:** _____ **Date:** _____