Client Information and Health History

Today Date: _____

Client's Name (First & Last): _____ Age:_____ DOB: ____/____/____

Address: _____City: _____ State: _____ Zip:_____

Pharmacy Name: _____ Pharm Contact Number: _____

Emergency Contact Name: _____ Number: _____

Provide your contact numbers(s) and/or email. ***Check below for your preferred method of contact. Please PRINT clearly.***

❑ **Home Phone** *(_____)*_____-_____ ❑ **Mobile (_____)**_____-_____

❑ **Email:**_____**@**_____

MARKETING PROMOTIONS

Would you like to receive office promotional emails? YES NO

Would you like to receive office promotional text messages? (Standard rates will apply) YES NO

How did you hear about us? *(Please list referral name)*

_____

PERSONAL PROFILE AND HEALTH HISTORY-FEMALE ONLY

Are you pregnant and/or breastfeeding? YES NO

Are you planning pregnancy during course of treatment? YES NO

During pregnancy did you develop hyperpigmentation? YES NO

Do you have regular periods? YES NO

Are you going through menopause? YES NO

Are you currently taking any of the following? (Circle all applicable)

NSAIDS/Aspirin/Ibuprofen Fish Oil CoQ10 Turmeric Coumadin Alcohol

Blood Thinners/Other:_____

If other, please list all medications you are currently taking or have taken over the past two months below.

_____

Allergic Reactions:*(Check all that apply)* Lidocaine Tetracaine Epinephrine Other

If other, please list all allergic reactions below.

_____

Are you allergic to any medications and/or products? If Yes, please list below. YES NO

_____

MEDICAL HISTORY: *(Please Check all that apply)*

❑ Acne	❑ Thyroid disease	❑ Cold sores/fever blisters
❑ Hirsutism	❑ Bleeding disorders	❑ Cardiac conditions
❑ Toxin Treatment	❑ Filler injections	❑ Hepatitis
❑ Vitiligo	❑ Hormone replacement	❑ Metal or other implants
❑ Rosacea	❑ Lupus	❑ Keloid scars
❑ Pacemaker	❑ Burns/Skin Grafts	❑ Shingles
❑ Cancer	❑ Heart disease	❑ HIV / AIDS / STDs / Herpes
❑ Implants	❑ Hernia Repair	❑ Psoriasis/Eczema
❑ Polycystic ovary disease	❑ Seizures	

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SKIN CONDITION(S) HISTORY

❑ None or If you have had any skin conditions, provide details. _____

PAST SURGERIES

❑ None OR List All Past Surgeries: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you/are you using medications such as Accutane?	YES	NO
Date of last use:_____/_____/_____		
Are you using Retina-A, Renova, Differein, Tazorac? *Concentration* _____*%*	YES	NO
Are you currently using, or have you used a tanning bed or self tanner?	YES	NO
Does your skin remain discolored after healing from a cut?	YES	NO

SKINCARE REGIME: *(Optional)*

AM Regime:_____

PM Regime:_____

PLEASE INDICATE THE SERVICE(S) YOU ARE INTERESTED IN OR WOULD LIKE MORE INFORMATION ON:

- ❑ Fine Lines/Deep Wrinkles/Creases
- ❑ Lip Enhancement/Lip Line
- ❑ Aged Skin/Sun Damage
- ❑ Dark Circles/Aging Hands
- ❑ Skin Laxity/Texture
- ❑ Chemical Peels/Facials
- ❑ Pigment Changes/Melasma
- ❑ Dry/Sensitive Skin
- ❑ Acne/Oily Skin
- ❑ Scar Treatment
- ❑ Enlarged Pores/Blackheads
- ❑ Facial/Body Hair and/or Vein Reduction
- ❑ Stubborn Fat/Cellulite
- ❑ Chin Fullness/Fat
- ❑ Rosacea Treatment
- ❑ Hair Loss
- ❑ Skin Care Regime
- ❑ Urinary Incontinence
- ❑ Other:_____

ACKNOWLEDGEMENT:

I understand that withholding information about my health could affect the outcome of my treatments or procedures; all of my health information stated above is current, accurate and true. **I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.**

I understand that I release Renew Laser & Skin and its associates, the consulting physician, the laser technician, and any other person involved in my treatment from any liability associated with complications from procedure(s) and I understand there are no guarantees. I have read and fully understand the content of this permission and authorize the performance of laser and/ or treatments recommended for me by the staff of Renew Laser & Skin.

Client/Legal Guardian Signature_____DATE:_____

Physician Signature:_____ DATE:_____