



6051 Arlington Blvd, Suite B,
Falls Church, VA 22044
703.241.2173

1880 Howard Ave, Suite 203
Vienna, VA 22182
703-356-6143

HEALTH HISTORY INFORMATION

NAME Today's Date:
LAST: FIRST: M.I:

HOME ADDRESS:

DATE OF BIRTH: AGE: Sex: Female Male

HOME PHONE: CELL PHONE:

EMAIL:

I consent to this email address to be added to the Med Spa and will be used to send email and newsletter, where I will get information on specials and promotions. Yes No

LEAVE MESSAGES AT: Home Cell Email

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, Jevaderm, Restylane, Collagen, etc.} AND DATES PERFORMED.

MEDICAL HISTORY

DO YOU HAVE APACEMAKER OR DEFIBRILLATOR?.....

DO YOU SUFFER FROM "PHOTOSENSITIVITY" {EXTREME SENSITIVITY TO SUNLIGHT}

DO YOU HAVE A HISTORY OF EASY/EXCESSIVE HYPERPIGMENTATION?.....

DO YOU FORM KELOID SCARS?.....

DO YOU HAVE ANY METAL IMPLANTS?.....

DO YOU WEAR CONTACT LENSESES?.....

HAVE YOU TAKEN ACCUTANE, RETIN A, OR RENOVA IN THE PAST 12 MONTHS?.....

ARE YOU CURRENTLY TAKING COUMADIN [Warfarin] OR OTHER BLOOD THINNERS?.....

DO YOU REQUIRE ANTIBIOTICS BEFORE PROCEDURES SUCH AS DENTAL CLEANINGS?.....

DO YOU SMOKE? Yes No IF YES, HOW MANY 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?.....

IF SO, PLEASE LIST:

DO YOU HAVE ANY OTHER ALLERGIES?.....

IF SO, PLEASE LIST:

DO YOU TAKE ANY OF THE FOLLOWING [Please check]:

all that apply and/or list additional medications

ANTI-COAGULANTS

ANTI-DEPRESSANTS

APPETITE DEPRESSANTS

ASPIRIN OR IBUPROFEN

BLOOD PRESSURE MEDICATION

CORTISONE OR STEROIDS

ANTIBIOTICS

HORMONES/CONTRACEPTIVES

INSULIN

NSAIDS

SEDATIVES

THYROID MEDICATION

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]:

- | | |
|---|---|
| <input type="checkbox"/> Active Infection | <input type="checkbox"/> 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 Disorders | <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"/> Endocrine/Hormonal Issues | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin Injury |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Unusual Moles |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Vision Deficits |
| <input type="checkbox"/> High/Low Blood Pressure | <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 THE 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
EPILATORIES

PLEASE INDICATE YOUR CURRENT SKIN CARE PRODUCTS/REGIMEN:

THERAPIST/PROVIDER REVIEWED: SIGNATURE _____ DATE _____

THERAPIST PRINTED NAME:

EXCLUSIONARY CRITERIA FORM

Yes <input type="checkbox"/> No <input type="checkbox"/>	I have had unprotected sun exposure, used a tanning Bed or applied a tanning cream in the area(s) to be treated within the six weeks prior to my first treatment on a regular basis (tanned skin will not be treated with laser). Protected sun exposure means wearing protective clothing or the daily use of an SPF-30 or greater sunscreen.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I have used a mechanical form of epilation with the six weeks prior to my first treatment (this applies to laser hair removal treatments only.) Mechanical epilation includes Plucking, waxing, tweezing, electrolysis, threading, or sugaring.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I have a history of seizures. Flashing lights may trigger a seizure.
Yes <input type="checkbox"/> No <input type="checkbox"/>	Medications I am taking Accutane, anticoagulants or St. John's Wort. I am taking a medication or herbal remedy that may make my skin sensitive to light (photosensitizing).
Yes <input type="checkbox"/> No <input type="checkbox"/>	I have a history of keloid and hypertrophic scar formation. Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason, it is recommended to exclude from treatment clients with known tendency to form keloid or hypertrophic scars. Clients with this history are evaluated on a case-by-case basis to determine if treatment can be performed.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I have an active infection or am immune suppressed. (Active infections and immuno- suppression compromise the healing ability of the body).
Yes <input type="checkbox"/> No <input type="checkbox"/>	I have an open lesion in the area to be treated.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I have a history of Herpes I or II within the area to be treated.
Yes <input type="checkbox"/> No <input type="checkbox"/>	I am using or have used within the two weeks prior to treatment Tretinoin (Retin-A, Renova) or a retinol product in the area to be treated.

PLEASE NOTE A "YES" TO ANY OF THE ABOVE MAY EXCLUDE CLIENT FROM THE LIGHT THERAPY (LASER/IPL) TREATMENTS.

PRINT CLIENT NAME:

SIGNATURE:

DATE:

WITNESS:

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="radio"/> Skin discoloration	
<input type="radio"/> Brown Spots	
<input type="radio"/> Acne	I have used Accutane: Yes <input type="radio"/> No <input type="radio"/> Last Dose:
<input type="radio"/> Rosacea	
<input type="radio"/> Fine Wrinkles	
<input type="radio"/> Lip Lines	
<input type="radio"/> Thin Lips	
<input type="radio"/> Nasolabial Creases	
<input type="radio"/> Marionette Lines	
<input type="radio"/> Loose Skin	
<input type="radio"/> Aging Hands	
<input type="radio"/> Excessive Sweating	
<input type="radio"/> Facial/Body Hair	
<input type="radio"/> Scars	
<input type="radio"/> Facial Veins	
<input type="radio"/> Leg Veins	
<input type="radio"/> Not Certain	
<input type="radio"/> Toenail Fungus	
<input type="radio"/> CoolSculpting Body Contouring	
<input type="radio"/> Other	

CLIENT SIGNATURE:

DATE:

PRINTED NAME:

PROVIDER NAME AND SIGNATURE:

DATE: