advanced skin fitness®
LASER & SKIN CARE

HEALTH HISTORY

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

PERSONAL INFORMATION

Name ____ Date ____________ DOB _____________Age_______

Address ____ Sex: ___ Female ___ Male

City _______________________________________ State _________________ Zip Code ______________

Home Phone ________________ Work ________________ Mobile _______________ Other ___________

Email: ____ ___

How did you hear of us? Google Yahoo Dallas Voice Existing Patient Other ____________________

I AM INTERESTED IN: (Please check all that apply)

O HAIR REMOVAL **O** SKIN REJUVENATION **O** SKIN CARE ADVICE / PRODUCTS

O SKIN TIGHTENING **O** ACNE SCAR TREATMENT **O** MICRODERMABRASION/CHEMICAL PEELS

O ROSACEA TREATMENT **O** SUN DAMAGE / AGE SPOTS **O** FACIAL VEIN TREATMENTS

O ACNE TREATMENTS **O** LASER LEG VEIN TREATMENTS **O** TEETH WHITENING

O CELLULITE TREATMENT **O** PHOTOFACIAL **O** FAT/VOLUME REDUCTION

O OTHER, PLEASE SPECIFY ____

DO YOU USE SUNSCREEN **O** YES **O** NO IF YES, SPF # AND BRAND _____________________

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

O ALWAYS BURN, NEVER TAN **O** USUALLY BURN, TAN WITH DIFFICULTY **O** SOMETIMES BURN, TAN ABOUT AVERAGE

O ALMOST NEVER BURN, TAN VERY EASILY **O** RARELY BURN, TAN EASILY **O** NEVER BURN, ALWAYS TAN

MEDICAL HISTORY (Please circle your answer)

ACCUTANE	YES	NO	HEPATITIS	YES	NO
ACNE	YES	NO	HIRSUTISM	YES	NO
ALLERGIES (drug or latex)	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS	YES	NO	HIV POSITIVE	YES	NO
AUTOIMMUNE DISORDER	YES	NO	KELOID SCARS (other scars)	YES	NO
BLOOD DISORDERS	YES	NO	KIDNEY DISEASE	YES	NO
CANCER (radiation therapy)	YES	NO	METAL PINS IN BODY	YES	NO
COLD SORES	YES	NO	MELANOMA	YES	NO
CONTACT LENSES	YES	NO	PACEMAKER	YES	NO
DERMATITIS/ECZEMA	YES	NO	RETIN A	YES	NO
DIABETES	YES	NO	PCOS (polycystic ovarian)	YES	NO
EPILEPSY	YES	NO	SKIN PIGMENTATION	YES	NO
GENETIAL HERPES	YES	NO	STD'S	YES	NO
HORMONAL IMBALANCE	YES	NO	Steroid or Hormonal Therapy	YES	NO
HEART CONDITION	YES	NO	SHINGLES	YES	NO
HEMOPHILIA	YES	NO	VITILIGO	YES	NO

Please Initial _______________
Please fill out other side.

ADDITIONAL QUESTIONS:

1. ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? **YES** **NO** IF YES, PLEASE SPECIFY.

____

2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, OR MEDICAL PATCHES? **YES** **NO** IF YES, PLEASE SPECIFY.

____

3. DO YOU HAVE ANY ALLERGIES? **YES** **NO** IF YES, PLEASE SPECIFY.

____

4 HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? **YES** **NO** IF YES, PLEASE SPECIFY.

____

5. HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? **YES** **NO** IF YES, PLEASE SPECIFY WHEN.

____

6. HAVE YOU EVER HAD A CHEMICAL PEEL? **YES** **NO** IF YES, PLEASE SPECIFY.

____

7. HAVE YOU HAD ANY LASER TREATMENTS? **YES** **NO** IF YES, PLEASE SPECIFY.

____

8. WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

____

9. DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? **YES** **NO** IF YES, PLEASE SPECIFY.

____

10. DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? **YES** **NO** IF YES, PLEASE SPECIFY.

____

11. DO YOU HAVE A PACEMAKER? **YES** **NO**

12. HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)? **YES** **NO** IF YES, PLEASE SPECIFY.

____

13. DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? **YES** **NO** IF SO, THEN HOW OFTEN?

____

14. HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS) **YES** **NO**

15. ARE YOU CURRENTLY PREGNANT OR TRYING TO GET PREGNANT? **YES** **NO** **YOU MUST INFORM US IF YOU BECOME PREGNANT DURING TREATMENTS.**

16. HAVE YOU HAD RESTYLANE, PERLANE, HYLAFORM OR BOTOX INJECTIONS IN THE AREA TO BE TREATED? **YES** **NO** IF YES, PLEASE SPECIFY.

____

17. DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES? **YES** **NO** IF YES, PLEASE SPECIFY.

____

How soon would you like to begin treatments? Very Soon Near Future Today if Possible

Please sign below to indicate all the information on this for is accurate and complete.

Signature ______________________________________ Date ____________________

Patient Consent for Dysport® Injections

Patient Name: ____

Procedure: Dysport® Botulinum Toxin A Injections

This is an informed consent document that has been prepared to help inform you concerning DYSPORT® injections, its risks, and alternatives treatments(s). It is important that you read this information carefully and completely. Please discuss any questions you may have with your provider. Once you have read and understood this information, and had any questions addressed to your satisfaction, please sign and date this consent

I hereby authorize and direct any associates or assistants of Advanced Skin Fitness to perform Dysport® Botulinum Toxin A injections on me. I specifically acknowledge that no guarantees or warranties have been made concerning the results of the procedure.

The following points have been discussed with me and I understand: (please initial each statement)

_____ DYSPORT® injections involve a series of small subcutaneous injections designed to weaken certain muscles that cause skin wrinkling. Weakening of the injected muscles begins to be apparent after 2-3 days with the peak effect being reached after 7-14 days. Results can last 3-6 months. The procedure can be repeated after 3 months; however, injections given at less than 3 month intervals may not produce a noticeable effect.

_____ Alternative forms of non-surgical and surgical management for the appearance of wrinkles and lines in the skin include laser ablation, chemical peels, dermal filler, minimally invasive procedures and face lift have been discussed with me. Alternative forms of treatment are all associated with certain risks.

_____ I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

______ I confirm that I am not pregnant at this time. I acknowledge that it is my responsibility to let my technician know if I become pregnant before my next treatment.

_____ I hereby authorize Advanced Skin Fitness or any associates to take pictures of the treated area to be used in my patient file.

RISKS OF DYSPORT® INJECTIONS

Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo a procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do no experience these complications, you should discuss each of them with your provider to make sure you understand the risks, potential complications, and consequences of DYSPORT® injections.

_____ **Bleeding --** It possible, though unusual, to experience localized bleeding episode during or after the procedure at the site(s) of injection. **Do not take any aspirin or anti-inflammatory medications for ten days prior to your DYSPORT® injection appointment.**

_____ **Bruising --** Following this procedure, it is not uncommon to bruise at the injection site. Bruising is usually resolved in 3-4 days.

_____ **Infection --** Infection is unusual. Should an infection occur, additional treatment including antibiotics may be necessary.

_____ **Unsatisfactory Results --** You may be disappointed with the results of the procedure. The procedure may result in unacceptable visible deformities, loss of function and/or loss of sensation.

_____ **Allergic reactions --** In rare cases, local allergies to botulinum toxin A preparations (including DYSPORT®) have been reported. Systemic reactions, which are more serious, may result from any medication or substance used during the procedure. Allergic reactions may require additional treatment.

Patient initials ____________

______ **Drooping of the eyelids (Ptosis) --** This is a rare but transient complication occurring in 1-2% of patients. The incidence can be minimized by positioning post injections. Ptosis usually resolves within several weeks but may take longer.

______ **Additional Procedures --** Should complications occur, other treatments may be necessary. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with DYSPORT® injections. Although good results are expected, there cannot be any guarantee or warranty expressed or implied with regard to the results that may be obtained.

_____ The most **common side effects** associated with the treatment of the glabellar lines are nose and throat irritation, headache, injection site pain, injection site skin reaction, upper respiratory tract infection, eyelid swelling, eyelid drooping, sinus inflammation, and nausea. Twenty-eight percent of patients experience one of these common side effects after their first Dysport® treatment.

ACKNOWLEDGEMENT

Informed consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s).
The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered.
Informed consent documents are not intended to define or serve as the standard of medical care.
Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

I have read the above consent and **1) had each item explained to me, 2) was given an opportunity to ask questions, and 3) had all of my questions answered.** I understand that I release Advanced Skin Fitness and its associates, the Medical Director, the injection technician performing services, and any other person involved in my treatment from any liability associated with complications from the Dysport® injection.

I am aware that Advanced Skin Fitness has a 24 hour cancellation policy. Similarly, I will be charged $100 for any broken appointment without 24 hour cancellation. I understand that all procedures are priced per treatment. I understand that no guarantees can be made and all payments are non-refundable. By my signature below, I certify that I have read and fully understand the contents of this permission and authorize the performance of Dysport® injection by the staff of Advanced Skin Fitness.

Patient name printed: ____

Patient signature and date ____

Healthcare witness signature and date ____

Credit Card Charge Authorization Agreement

We request the courtesy of a 24 hour notice in the event an appointment needs to be cancelled or rescheduled. A $75 no show fee for facial treatments and a $100 no show fee for laser treatments will apply in the event advanced cancellation notice is not given. Appointments booked same day of service will be assessed a no show fee should cancellation become necessary. For treatments that are pre-paid, the pre-paid treatment will be forfeited without 24 hour notice of cancellation. Thank you for your cooperation.

I, ____,

hereby authorize Advanced Skin Fitness to charge my credit card used for my treatments in the amount of $75 for a missed facial treatment or $100 for a missed laser treatment.

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback Advanced Skin Fitness, as long as I receive the services that are entitled to me and guidelines are followed for my rescheduling and cancellation of appointments. Twenty-four hour notice is required for all rescheduling and cancellations.

Name On Card: ____

Signature: ____

Credit Card Billing Address: ____

City, State, Zip: ____

Telephone: (_____) ______________

Date: ____/____/____