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 ______________________________

advanced skin fitness
LASER & SKIN CARE

LASER TREATMENT PATIENT EVALUATION

This information will help our office to better evaluate your skin type so the laser treatment will be more effective. Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your practitioner are:

- **Genetic Disposition**
- **Reaction to Sun Exposure and Tanning Habits**

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes the color of your eyes, hair, etc. The way your skin responds to sun exposure is another way of correctly assessing your skin type. Recent tanning, whether by the sun or an artificial tanning booth, even tanning creams, can have a major impact on your skin color evaluation.

By using the information you provide on this form, we can be better prepared to provide you with the best care. Please take a few minutes to fill out this questionnaire.

Genetic Disposition

Score	0	1	2	3	4
Your natural eye color?	Light Blue, Green, or Gray	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
Natural color of your hair?	Sandy, Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
Color of your non-exposed skin?	Reddish	Very Pale	Pale with beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Total score for genetic disposition: _____

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	Rarely burn	Never burn
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan every 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

Total score for reaction to sun exposure: _____

Patient Evaluation: Pg. 2

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun or tanning booth/cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for tanning habits: _____

Summary

Add up the total scores for each section for your Skin Type Score to give you a better evaluation of your skin type.

______ **Total score for Genetic Disposition**

______ **Total score for Reaction to Sun Exposure**

______ **Total score for Tanning Habits**

______ **Skin Type Score**

Fitzpatrick Skin Type:

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V - VI

NAME: ____ **DATE:** ______________

COMMENTS: ____

____

advanced skin fitness®
LASER & SKIN CARE

Patient Consent for Treatment of Vascular Lesions

Patient Name: ____

Procedure: Treatment of Spider Veins
Lasers: Variable Pulsed Nd:Yag (1064nm) – Candela GentleYag

I hereby authorize and direct any associates or assistants of Advanced Skin Fitness to perform Candela GentleYag treatment on me for vascular lesions or spider veins. Although one treatment can typically eliminate the vascular lesions, multiple treatments may be required to achieve cosmetically acceptable results depending on the size and color of the lesion being treated. 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)

_____ The potential benefits of Nd: Yag treatment for spider veins.

_____ The most likely possible complications or risks involved with GentleYag treatment include, but are not limited to blistering with infection and scarring, scabbing, bruising, and long-term pigmentary changes (hypopigmentation or hyperpigmentation.)

_____ The Candela GentleYag is a device that produces an intense gut gentle burst of light that treats the abnormal blood vessels see in spider veins or other cutaneous vascular lesions without harming the surrounding tissue.

_____ Other methods of treating this type of lesion, such as Sclerotherapy for leg veins or another therapy for other vascular lesions has been discussed with me.

_____ Topical anesthetic creams will lessen the discomfort in sensitive areas.

_____ **Eye protection must be worn at all times during the treatment.**

_____ I hereby authorize Advanced Skin Fitness or any associates to take pictures of the treated area to be used in my patient file and/or teaching purposes. I understand that the release of this information will be kept confidential and that no patient names will be used.

_____ I understand that immediately following the laser treatment, the treated area will appear as a red or bruised discoloration and have edema (swelling) followed by possible scabbing of the treated areas. The redness (erythema) and discoloration may take up to 6 months to heal. The treated area will feel tender for a few hours after the treatment.

_____ Improper care of the treated area while the discoloration is present may increase the chance of scarring or skin textural changes to the treated area. Compliance with recommended aftercare guidelines are crucial for healing, prevention of scarring and hyperpigmentation. I am aware that a topical antibiotic cream may be used and that I should avoid picking at any scabs until the area has fully healed.

ACKNOWLEDGEMENT

I understand that I release Advanced Skin Fitness and its associates, the Medical Director, the laser technician performing services, and any other person involved in my treatment from any liability associated with complications from the laser procedure. 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 spider vein reduction by the staff of Advanced Skin Fitness.

Patient or legal guardian signature and date ____

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: ____/____/____