Skin Consultation Form

Patient Information

First	Last	Date
Date of Birth	Sex Female Male	Member #
Address		
City	State	Zip Code
Email Address	Phone Number	
Emergency Contact	Contact's Phone	

Medical Background

Current Skin Concditions	
Medical History	
Surgical History	
Are you currently or have you ever taken Retin A Accutane Niether	Do you have a history of cold sores? Yes No
Are you on oral or topical antibiotics? Oral Topical Niether	Antibiotic Name
How many times do you exercise per week?	What is your stress level? Low 1 2 3 4 5 6 7 8 9 10 High
Hours of sleep per night	How many 8 oz. glasses of water do you drink in one day?
Do you smoke? Yes No	How much UV exposure (sun, tanning beds, commuting in cars, etc.) do you get? High Moderate Low
List all supplements, medications (including blood thinners) and allergies	

Patient Self-Assessment

Do you have any of the following? Scars Stretch Marks Hyper Pigmentation
Do you suffer from Acne Blackheads Whiteheads Milia Oiliness Dehydration Eczema Cellulite Psoriasis Vein/Circulation Problems
Have you ever recieved any of the following treatments Facial Microdermabrasion Laser Surgery Chemical Peel Waxing Lash/Brow Tint Laser Hair Removal Vein Treatments
Please circle the description that applies to you I never tan I tan with difficulty Average tanning, somtimes burning Easily tan, rarely burn I never burn

Informed Consent to Treatment

I, ______________________________, allow the Skin Medicus esthetician to perform skin exfoliations, facial treatments, chemical peels and other skin related services on my body and/or face.

Services: ____

I have not used Retin A, a scrub, a take home microdermabrasion or a glycolic peel in the last 72 hours. ______(intial)

I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks. ______(intial)

Possible side effects to chemical peels include, but are not limited to, mild redness, dry skin and flaking. Most side effects are temporary and generally fade within 72 hours. ______(intial)

I have no allergies to iodine (Seaweed). ______(intial)

I am not epileptic and do not have heart or circulation problems. ______(intial)

It is recommended to discontinue use of all AHA's, glycolics, Retin A, Renova, or any exfoliation products for up to 72 hours post clinical procedure as well as using hydrating, soothing, antioxidants for healing. No sun exposure or tanning beds for up to 72 hours. The daily use of at least SPF 15 sunscreen is recommended pre and post procedure. ______(intial)

I agree to adhere to all safety precautions and the home skin care program set out by the Skin Medicus esthetician. ______(intial)

I am over 18 years of age or have parental consent (shown by the parent signature below). ______(intial)

I will call to inform the office of any complications or concerns I may have as soon as they occur. ______(intial)

I have been off Accutane for at least 12 months. ______(intial)

The nature and purpose of the treatment has been explained to me, and any questions I had regarding this procedure has been explained to my satisfaction. ______(intial)

I have voluntarily elected to undergo this treatment/procedure after its nature and purpose has been explained to me as well as the risks involved. Although it is impossible to list every potential risk and complication, I have been informed of the possible benefits, risks and complications. I also recognize there are no guaranteed results and that individual results are dependent upon age, skin condition and lifestyle. I have read and understood the post-treatment home care instructions. I have also, to the best of my knowledge, given an accurate account of my medical history.

I have read and fully understood this agreement and all the information detailed above. I do not hold the esthetician or Skin Medicus responsible for any of my conditions that were present but not disclosed at the time of the procedure that may have been effected by the procedure performed today.

Signature ______________________________ Date ____________________

For treatment of a minor Parent/Gaurdian consent is needed:

Signature ______________________________ Date ____________________

Skin Medicus

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Appointment Cancellation Policy

As a result of not having any available appointments in our schedule and in order to best serve our patients, the following policy is necessary.

Please be aware that Skin Medicus will charge $50 fee for failed appointments NOT cancelled 24 hours prior to the scheduled appointment date.

Payment in full is necessary prior to any treatments being rendered. The payment is non-refundable and non-transferable. In the event that you are unable to complete a pre-paid treatment regimen you could finish the treatment at a later date. (Up to one year from your last appointment)

By signing below I agree that I was informed of this office policy.

X____

____

(Patient Name)

Date ______/______/______