ETERNAL BEAUTY
MEDICAL AESTHETICS

Confidential Client History & Consent Form

Date:_____

Name: _____ D.O.B.:_____

Address:_____City:_____St:_____Zip:_____

Home Phone:_____ Cell Phone:_____

E-mail Address:_____

Emergency Contact:_____ Phone:_____

How did you hear about us (i.e. website, friends name, newspaper, ad, facebook, etc)?

_____

Please list any questions or concerns that you have with your skin and/or the reason for your visit:

_____

Which skincare and cosmetic products are you currently using?

_____

1)Have you been under the care of a physician, dermatologist, or other medical professional within the past year? ○No ○Yes

(If yes, explain)_____

2) Any recent surgery, including plastic surgery? ○No ○Yes

(If yes, explain)_____

3) Do you smoke? ○No ○Yes

4) Do you follow a restricted diet? ○No ○Yes

5) What is your stress level? ○High ○Medium ○Low

6) List any medications or vitamins you are taking regularly:_____

7) Do you wear contact lenses? ○No ○Yes

8) Have you been exposed to the sun or a tanning bed within the last 48 hours? ○No ○Yes

90) Do you use or have you ever used Adapalene Hydroxl Acid, Glycolic Acid, AHA, Accutane, Retin-A, Renova, Deferin, Salicylic Acid or **Accutane**? ○No ○Yes

If yes, please explain:_____

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Have you ever experienced an allergic reaction to any of the following? (please circle any that apply)

Cosmetics Medicine Food Sunscreens Iodine

Fragrance Shellfish Latex

Other:_____ If yes, please explain: _____

Are you allergic to any medications? _____

10) Have you ever experienced claustrophobia? ONO o Yes

11) Do you have a pacemaker, filter or any medical device implanted? ONO [0]Yes 13) Have you had any of the following health conditions in the past or present?

Cancer	Headaches
Hormone Imbalance	Hepatitis
High/low blood pressure	Fever blisters/cold sores
Hysterectomy	Immune disorders
Spinal injury	HIV/AIDS
Diabetes	Poor circulation
Heart problem	Insomnia
Varicose veins	Skin diseases/skin lesions
Arthritis	Any active infections
Asthma	Eczema
Epilepsy	Scar easily

Female Clients Only

14) Are you taking any oral contraceptives? [O]NO [o] Yes

15) Are you pregnant or trying to become pregnant? ONO [O] Yes 10) is the date of your last menstrual cycle?_ _____ _

I understand, have read and fully completed this questionnaire truthfUlly. I agree that this constitutes Kill disclosure, and that it supersedes any previous verbal or written disclosures. While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client, therefore no guarantee can be given. I also understand that withholding inf0rmation or providing misinfbvmati011 may result in contraindications and/or irritation to the sl<in from treatments received. I am aware that it is my responsibility to inf0rm the technician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Eternal Beauty Meclical Aesthetics and my esthetician from liability and assume full responsibility thereof.

I consent 10 photos being used for office use/advertising. ONO oYes

Client signature:_____ Date:_____ _ _ _ _

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We respect your privacy. Please indicate your communication preferences:

1. May we release your health information to your Primary Care doctor or other doctors you are involved in your care? Yes No

2. What is the best way for us to call you regarding your visit?
   - Can we call you at? Home Work Cell
   - Can we text you? Yes No
   - Can we email you? Yes No

   Please provide email: _____

3. If I am not at home or do not answer my cell phone ***Eternal Beauty Medical Aesthetics*** may leave a message on my answering machine or voicemail:
   - To return your call Yes No
   - Leave medical information such as:
     - Appointment time Yes No
     - Lab or X-ray reports Yes No
     - Medication information Yes No
     - General medical instructions Yes No

4. I give ***Eternal Beauty Medical Aesthetics*** permission to leave or give medical information to the following family or friends:

Name	**Relation**	**Phone**

NOTE: **No information** will be released concerning any patient including your spouse, mother, father, or any other person who feels they should be entitled to any information concerning our patient. If you wish to release information, the name of the person **MUST** be provided on this form. It will be your responsibility to keep this list current. You may remove or names at any time. Signature and date are required at each revision.

Signature_____ **Date**_____