LASKY
AESTHETICS & LASER CENTER

HEALTH HISTORY INFORMATION

Name: _____ Today's Date: _____
Last First MI

Street address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ Sex: ☐ Female ☐ Male

Home Phone: _____ Cell Phone: _____

Email address: _____

I consent to this email address being added to the Lasky Aesthetics and Laser Center email newsletter, where I will get information on specials and promotions. ☐ Yes ☐ No

Occupation: _____

In case of Emergency, who should be notified? (name and phone) _____

Do you have any major medical problems, serious illness? ☐ Yes ☐ No If so, please list:

_____

_____

Please list all prior surgical procedures and dates performed:

_____

_____

MEDICAL HISTORY

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Do you suffer from "photosensitivity" (extreme sensitivity to sunlight)? ☐ Yes ☐ No

Do you have a history of easy/excessive Hyperpigmentation? ☐ Yes ☐ No

Do you form keloid scars? ☐ Yes ☐ No

Do you suffer from seizures? ☐ Yes ☐ No

Do you have any metal implants? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes quantity per week? _____

Please list all allergies:

_____

_____

_____

Are you allergic to any medication? ☐ Yes ☐ No

If so, please list:

Please list all medications below:

Name	Dosage	Frequency	Medical Condition

Are you taking vitamins? ☐ Yes ☐ No

Are you or might you be pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Do you currently have any of the following (please check all that apply):

- ☐ Active Infection
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blistering Sunburns
- ☐ Circulation Problems/Blood Clots
- ☐ Cold Sores / Shingles
- ☐ Collagen Disorder
- ☐ Diabetes (Type)
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Endorcrine / Hormonal Issues
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches / Migraines
- ☐ Heart Condition Hepatitis
- ☐ High / Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormonal Imbalance
- ☐ Insomnia / Sleeping Problems
- ☐ Joint Injury
- ☐ Multiple Sclerosis
- ☐ Muscle Pain / Spasms
- ☐ Neurological Disorders
- ☐ Permanent Makeup / Tattoo
- ☐ Pigmentation Disorders
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Recent Surgery
- ☐ Scleroderm
- ☐ Sensitive Teeth
- ☐ Skin Cancer
- ☐ Skin Injury
- ☐ Stroke
- ☐ Unusual Moles
- ☐ Varicose Veins
- ☐ Vision Deficits
- ☐ 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

Please indicate your current skin care products/regimen:

_____

_____

_____

Provider Reviewed (sign) _____ Date: _____

ACKNOWLEDGEMENT OF PRACTICE POLICIES

I understand that I will be required to pay a $50 consultation fee that will be applied towards the cost of any treatment. In addition, prior to any treatment is performed you will be required to sign an informed consent. Any treatment performed at Lasky Aesthetics and Laser Center is cosmetic in nature and the decision to proceed is based on my desire to do so: _____ (Please Initial)

PAYMENT POLICY

I understand that my treatments at the Lasky Aesthetics and Laser Center require payment and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by the Lasky Aesthetics and Laser Center. For cosmetic medical procedures, I understand that the services often require more than one session for best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There is no guarantee of refunds on treatments paid in advance. Any refunds will be determined on a case by case basis after appropriate management approval. I further understand that the services offered by the Lasky Aesthetics and Laser Center are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, check or most major credit cards. _____ (Please Initial)

CANCELLATION AND LATE POLICY

We understand that sometimes it is necessary to re-schedule or cancel an appointment; however we ask that 24 hours notice is given prior to cancelling.

Name: _____ Date: _____

In the event that you are unable to give us 24 hours notice, a cancellation fee of $100 will be billed to your account. We regret any inconvenience this may cause. _____ (Please Initial)

RETURN POLICY

All sales of skin care and makeup products are final. Unopened products may be returned with a receipt for a credit within 30 days. _____ (Please Initial)

DISCLAIMER

I understand that all medical cosmetic treatments are provided exclusively by the Lasky Aesthetics and Laser Center. I will not hold the Lasky Aesthetics and Laser Center, its owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that the Lasky Aesthetics and Laser Center cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion: _____ (Please Initial)

I understand that even with the best laser and the highest trained technicians, as high as 10-15% of patients will not have a desired response/outcome to treatments. _____ (Please Initial)

CONSENT TO PHOTOGRAPH (check one or both)

☐ I consent to be photographed during the course of my treatment with Lasky Aesthetics and Laser Center. I understand that the purpose of such photographs are to track the progress of my treatment(s). I understand that my photographs are part of my medical records and therefore, are the property of Lasky Aesthetics and Laser Center. I consent to the use of my photographs, at the discretion of Lasky Aesthetics and Laser Center for marketing, research, educational and/or scientific purposes. I understand that every attempt will be made to protect my identity and my name will not be disclosed.

Print Patient name: _____

Signature: _____ Date: _____

PRIVACY

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent.

Print Patient name: _____

Signature: _____ Date: _____

Name: _____ Date: _____

COSMETIC INTEREST QUESTIONNAIRE

Please check all that apply and indicate any prior treatments in space provided or notes you want to discuss with your provider:

X	Intrests	Notes
	Dry or Oily Skin	
	Tired looking skin or uneven skin tone	
	Brown spots, sun damage or “hyperpigmentation”	
	Clogged or Large Pores	
	Acne	
	Roscea or racial redness	
	Fine or deep wrinkles	
	Lines around the nose or mouth	
	Facial volume loss	
	Neck wrinkles / loose skin	
	Frown lines between the brows	
	Lip lines or thin lips	
	Length or fullness of eyelashes	
	Loose or sagging skin	
	Ageing hands	
	Facial or Body Hair	
	Scars (Acne or Surgical)	
	Skin Tightening (face or body)	
	Cellulite	
	Body Contouring/Coolsculpting	
	Facial Veins	
	Leg Veins	
	Excessive sweating	
	IV Vitamin Therapy (anti-aging, wellness, fatigue)	

Client Signature: _____

Provider Signature: _____ Date: _____