LIGHTSheer™ **at Touch of Class Medspa & Laser Center (818) 502-3636**

BOTOX/DYSPORT and DERMAL FILLER Form

Client Information and Medical History

In order to provide you with the most appropriate skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name ____ Today's Date_____________

Date of Birth _____/____/_____ Age ______ Gender ☐ M ☐ F Current Time_________am/pm

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other ____________________________

Occupation ____

Home Address ____

City________________________ State _______ Zip Code _________________

Home Phone (______) ________________Work Phone (______) _________________ ext._____

Cell Phone (______) __________________ Email _____________________________________

Emergency Contact Name _____________________________ Phone (______) _______________

Social Security Number ______-_____-_______ Driver's License Number ___________________

How were you referred to **or** heard of us? ____

____

Preferred Practitioner: ☐ Female Nurse ☐ Male Nurse ☐ **No preference**, whichever is available based on my requested appointment time.

<u>MEDICAL HISTORY</u>

1. Are you currently under the care of a physician? ☐ Yes ☐ No

2. Are you currently under the care of a dermatologist? ☐ Yes ☐ No

3. Do you have any of the following medical conditions? (Please check all that apply)

☐ **NONE**
☐ Cancer
☐ Diabetes
☐ High blood pressure
☐ Herpes
☐ Arthritis
☐ Frequent cold sores
☐ HIV/AIDS
☐ Keloid scarring
☐ Skin disease / Skin lesion
☐ Seizure disorder
☐ Hepatitis
☐ Hormone imbalance
☐ Thyroid imbalance
☐ Blood clotting abnormalities
☐ Any active infection

4. Do you have any other health problems or medical conditions? Please list:

☐ **NONE**
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

5. What **oral medications** are you presently taking?

☐ Names (please list): ____

____

____

6. What **topical medications** or **creams** are you currently using?

☐ Names (please list):
1. ______________________________________
2. ______________________________________
3. ______________________________________

Question 7-9: Females Only

7. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
8. Are you using contraception? ☐ Yes ☐ No
9. Are you breastfeeding? ☐ Yes ☐ No

Allergies

10. Have you ever had an allergic reaction to any of the following?
(Please check all that apply and describe the reaction you experienced.)

- ☐ **NONE**
- ☐ Food
- ☐ Latex
- ☐ Cosmetics
- ☐ Aspirin
- ☐ Lidocaine
- ☐ Hydrocortisone
- ☐ Hydroquinone or skin bleaching agents
- ☐ Others: ____

Cancellation policy

Cancellation is required 24 hours prior to appointment; failure to cancel within the required time will result in a fee of $25.00 being charged to the credit card on file. A No Show is considered failure to cancel or failure to show for a scheduled appointment, a fee of $50.00 will be applied to the credit card on file.

I attest this information to be true, knowing my technician relies on this for safe and effective treatment; I understand the cancellation policy and agree to its terms.

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature____ Date ____________________