# CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

**PERSONAL HISTORY**

Client Name_____________________________________________ Today's Date________________

Date of Birth__________Age__________Occupation_______________________________________

Home Address________________________ City_____________________ State___Zip Code_____

Home Phone (___)_________________________Work Phone (____)_________________________

Emergency Contact Name and Phone___________________________________________________

Email Address:____________________________________________________________________

How were you referred to us? _________________________________________________________

Do you regularly sun bathe or use tanning salons?_____________How often?__________________

**MEDICAL HISTORY**

Are you currently under the care of a physician? ❑Yes ❑ No

If yes, for what:___________________________________________________________________

___________________________________________________________________________________

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

❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis

❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions

❑Seizure disorder ❑Hepatitis ❑Hormone imbalance ❑Thyroid imbalance

❑Blood clotting abnormalities ❑Any active infection

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

___________________________________________________________________________________

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑Food ❑Animal Protein ❑Aspirin ❑Lidocaine ❑Hydrocortisone

❑Hydroquinone or skin bleaching agents ❑Others:____________________________________

____________________________________________________________________________

____________________________________________________________________________

**MEDICATIONS**

What oral prescription medications are you presently taking? ❑Birth control pills ❑Hormones

❑Others (It is required that you list all of them): _______________________________________

____________________________________________________________________________

What antibiotics do you use to treat infections?_________________________________________

____________________________________________________________________________

Do you take any medications for heart conditions? _____________________________________

____________________________________________________________________________

Are you on any mood altering or anti-depression medication?_____________________________

What topical medications or creams are you currently using? ❑ RetinA , ❑Others (Please list):

____________________________________________________________________________

What herbal supplements do you use regularly?_________________________________________

Would you like to receive cash rebates via email on MediSpa Services? ❑Yes ❑No

**HISTORY**

**<u>For our female clients:</u>**

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

*I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.*

Signature____________________________________________________ Date:_______________

# Latisse Informed Consent

I, ________________________________________________________, understand that I will be given a prescription for Latisse (bimatoprost ophthalmic solution) which is indicated to treat hypotrichosis (inadequate or not enough eyelashes) of the eyelashes by increasing their growth including length, thickness and darkness.

A. Contraindications

**Hypersensitivity**

1. Patients with hypersensitivity to bimatoprost or any other ingredient in this product

**Pregnancy**

1. While there are no adequate and well controlled studies for bimatoprost in pregnant woman Latisse should not be administered during pregnancy since the potential benefit does not justify the potential risk to the fetus
2. Nursing mothers should not take Latisse since many drugs are excreted in human milk

**Contact Lenses**

1. Latisse solution may be absorbed by soft contact lenses. Contact lenses should be removed prior to application of solution and may be reinserted 20 – 30 minutes following its use.

B. The possible side effects of Latisse include but are not limited to:

1. **Risks: I understand there is a risk of itching, increased blood in the eye, hyperpigmentation of the skin, irritation, dry eyes, redness, allergic reaction.**
2. **Infection:** Infections can occur which in most cases are easily treatable but in rare cases a permanent scarring in the area can occur.
3. Iris Pigmentation: Increased iris pigmentation has occurred. You should be advised that the potential for increased brown iris pigmentation is likely to be permanent should this side effect occur. Iris color changes may not be noticeable fore several months to years.
4. Lid Pigmentation: Bimatoprost has been reported to cause pigment darkening of the eyelid. This side effect has been reported to be reversible upon the discontinuation of treatment.
5. Intraocular Inflammation: Latisse solution should be used with caution in individuals with active intraocular inflammation (uveitis) because the inflammation may increase.
6. Macular Edema: Swelling of the small area of the retina responsible for central vision. The edema is caused by fluid leaking from the retinal blood vessels.

C. Use

1. Latisse must be used exactly as directed to reduce the risk of complications and side effects.
2. The Latisse bottle must be kept intact during use.
3. Place one drop on the single use per eye applicator.
4. Bottle tip should never be allowed to contact any other surface to avoid contamination
5. Sterile applicators may only be used on one eye and then discarded. Reuse of applicators increases the potential for contamination and infections.
6. Do not apply Latisse to bottom lashes
7. Do not use Latisse more than once per day. Additional application will not increase results but will increase the risk of possible complication and side effects.
8. Upon discontinuation of Latisse eyelash growth is expected to return to its pre-use level
9. Do not use Latisse on any other areas of the body. Studies have not been performed as to the safety and effectiveness in any area other than the eyelashes

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby release the doctor prescribing Latisse and the facility from liability associated with this procedure.

***Patient Signature*________________________________________*Date:*____________**