



BLUE DIVINE

AESTHETICS

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: **TEST_CLIENTFIRSTNAME TEST_CLIENTLASTNAME**

Date of Birth: **TEST_CLIENTBIRTHDATE** Age:

Occupation:

Home Address: **TEST_CLIENTADDRESS TEST_CLIENTCITY TEST_CLIENTSTATE**
TEST_CLIENTPOSTCODE

Mobile Phone: **TEST_CLIENTPHONE** Alternate Phone:

Emergency Contact Name: **TEST_EMERGENCYNAME** Phone: **TEST_EMERGENCYPHONE**

How were you referred to us?

Which of the following best describes your skin type? (Please check one)

- Always burns, never tans
- Always burns, sometimes tans
- Sometimes burns, always tans
- Rarely burns, always tans
- Brown, moderately pigmented skin
- Black Skin

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No **If yes, for what:**

Are you currently under the care of a dermatologist? Yes No **If yes, for what:**

Do you have a history of erythema abigne, which is a persistent skin rash produced by

prolonged or repeated exposure to moderately intense heat or infrared irritation?

Yes No

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

<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent cold sores	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hormone imbalance
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Keloid scarring	<input type="checkbox"/> Thyroid imbalance
<input type="checkbox"/> Herpes	<input type="checkbox"/> Skin disease/Skin lesions	<input type="checkbox"/> Blood clotting abnormalities
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Any active infection

Please answer the following questions:

Are you on any blood thinner medication such as heparin, coumadin, warfarin, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any cardiovascular problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any cortisone or steroid injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any cosmetic injections, filters or implants (i.e. Botox, collagen)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have eczema or psoriasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have enlarged or painful glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had facial waxing services performed within the past 7-14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any heart ailments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any inflammatory conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on any light sensitive medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have loose, thin or aged skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any lymphatic disorders, inflammations of lymph vessels or lymph edema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a pacemaker or metal implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have phlebitis or varicose veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in a recent accident or had a serious injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a recent surgical or dental procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have rosacea or telangiectasia/couperose?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any skin abrasions or lesions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you using any skin-lightening or bleaching agents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a sunburn?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have swollen or infected tonsils?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you under medical care for an existing or suspected condition or disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a viral infection or influenza?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents

Others:

MEDICATIONS

What oral medications are you presently taking? Birth control pills Hormones Others
(Please list):

Are you on any mood altering or anti-depression medication? Yes No If yes, please list:

Have you ever used Accutane? Yes No If yes, when did you last use it?

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

What herbal supplements do you use regularly?

HISTORY

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe:

For our female clients:

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:

TEST_CLIENTSIGN

PERSONAL INFORMATION

What is your current level of stress from 1-10?

How many ounces of water do you drink daily?

Do you regularly sun bathe or use tanning salons? Yes No How often?

When was your last sunburn?

Do you spray tan? Yes No If yes, where:

When in the sun, do you burn? Always Sometimes Rarely Very rarely Never

What skin brands are you currently using?

Which skin conditions are you currently concerned about? Wrinkles Sun spots Dull skin Dry/rough Other:

Do you use a daily environmental protection product/sunscreen? Yes No If no, why not?

Rate how you feel about the quality of your skin from 1-10 (1 being bad, 10 being fantastic):

Your skin type is: Normal Dehydrated Oily Acne/Acne prone Sensitive Rosacea

In order of importance, please rank 1 (most important) to 5 (least important):

- Reduction of fine lines
- Reduction of brown spots/sun damage
- Reduction of oil/acne
- Acne scars diminished
- Reduction of redness

What do you like about your skin?

What don't you like about your skin?

Please complete the chart below. This information will help our office to better evaluate your skin type so the laser treatment will be more effective. Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type 1) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your practitioner are genetic disposition and reaction to sun exposure/tanning habits. By using the information you provide on this form, we can be better prepared to provide you with the best care.

What is your eye color?	Light blue or gray	Blue or green	Hazel or Light brown	Dark brown	Brownish black
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What is your natural hair color?	Red, sandy red	Blonde	Dark blonde chesnut, brown	Dark brown	Black
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have freckles on exposed areas?	Many	Several	Few	Incidental	None
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What happens when you stay in the sun too long?	Painful, redness blistering and peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burn	Never burn
	○	○	○	○	○
To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown easily
	○	○	○	○	○
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never has problems in sun
	○	○	○	○	○
When did you last expose yourself to the sun, tanning bed or self tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	○	○	○	○	○
How often is the area that you want to have treated exposed to the sun	Never	Hardly ever	Sometimes	Often	Always
	○	○	○	○	○

Skin Score (Total Number)

Skin Score	Skin Type
0 - 7	I
8 - 16	II
17 - 25	III
26 - 30	IV
Over 30	V - VI

Please read carefully and initial:

I have not used retin-A for 72 hours

Initial:

TEST_CLIENTSIGN

I do not have any active cold sores.

Initial:

TEST_CLIENTSIGN

I acknowledge that there is a rare possibility of an allergic reaction. I have previously used alphahydroxy acid products on my skin and/or in the past with no allergic reaction, but understand there still could be a response.

Initial:

TEST_CLIENTSIGN

I agree to avoid direct sun exposure for 48 hours.

Initial:

TEST_CLIENTSIGN

I agree to notify my esthetician of any concerns.

Initial:

TEST_CLIENTSIGN

I agree not to wax for 72 hours pre/post treatment.

Initial:

TEST_CLIENTSIGN

There will be a \$50 charge for patients who aren't shaved and need shaving. Your appointment may have to be rescheduled if you do not come shaved and our schedule

does not allow enough time to perform your treatment.

Initial:

TEST_CLIENTSIGN

Cancellation Policy:

We have a 24-hour cancellation policy. You will be charged full price for all appointments that are a no show and \$25 for appointments that are cancelled in less than the 24 hour period. You must have a credit card on file at all times while receiving treatments at Blue Divine due to this cancellation policy. No refunds.

Initial:

TEST_CLIENTSIGN

VEINS AFTER CARE FORM

Post Treatment Instructions:

1. Immediately after the treatments, you should apply an ice pack, as there may be mild swelling. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. If any crusting, apply antibiotic cream. Some physicians recommend aloe vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer. Follow instructions as specified by your laser professional.
2. Makeup may be used after the treatment has quit swelling unless there is epidermal bleeding. It is recommended to use new makeup to reduce the possibility of infection. Keep the area moist. Any moisturizer without alpha-hydroxy acids will work.
3. You may shower after the laser treatments in tepid water. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed.
4. You will experience redness and bruising from five to fourteen days at the treatment. Avoid sun exposure to reduce the chance of dark or light spots for 2 months. Use sunscreen SPF 25 or higher at all times throughout the treatment.
5. After the bruising has cleared it takes up to four weeks or longer to observe the maximal effectiveness of that particular treatment.
6. Avoid picking or scratching the treated skin to achieve your best results. Minimal pinpoint crusting can occur so keep the area moist with a Vaseline-type product and avoid picking.
7. Call your physician's office with any questions or concerns you may have after the treatment.

Informed Consent For Removal/Reduction of Brown Spots & Spider Veins

Name: **TEST_CLIENTFIRSTNAME TEST_CLIENTLASTNAME**

I authorize Blue Divine Aesthetics, experienced and trained in the removal of brown spots and superficial spider veins, to perform the procedure. The light pulsed system will dramatically reduce darkly pigmented sunspots and spider veins. More than one laser session may be necessary to achieve desired results. However, other treatments, including skin care products, are often needed to blend color, reduce sun damage, and give the best results. The FDA has given the clearance for removal of brown spots, spider veins, and

rosacea.

The skin treated will be red and swollen with fine, thin scabs forming. Please keep the treated areas covered with Polysporin and Aquaphor until the thin scabs fall off. This process will take anywhere from 1-3 weeks. It could take as long as 3-6 months in some cases. Do not scratch the scabs, which can cause scarring.

We are unable to treat clients that are on ACCUTANE, and PHOTSENSITIZING medications. Clients using ANTICOAGULANTS should be noted.

The following problems may occur with treatment:

1. **Scarring:** The light pulsed system can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be just below the blistering point which means skin will be red. Although it is certainly possible to scar with a burn or blister, it has not been a problem with the Medilux. However slight, there is a risk of scarring.

2. **Hyper-pigmentation** (browning) and **Hypo-pigmentation** (whitening) have been noted after treatment, especially with a darker complexion. This usually resolves within weeks, taking as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have a lot of color in your skin, a skin lightening cream will be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure after the treatment reduces the risk of color change.

3. **Infection:** Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a laser treatment. This applies to both individuals with a past history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatment including antibiotics might be necessary. **If you have a history of herpes simplex virus in the treated are we would recommend preventative therapy.**

4. **Bleeding:** Pinpoint bleeding is rare but can occur following brown spot and spider vein treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. **Laser Smoke (plume):** Although brown spot/solar lentigo removal treatment normally involves minimal laser smoke, the smoke is noxious to those who come in contact with it. This smoke may be representing a possible biohazard.

6. **Skin tissue pathology:** Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with your doctor for a clearance for the treatment.

7. **Allergic reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations, have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment.

8. Please wear sunscreen of SPF 25 or higher before and after treatment to protect your skin.

9. I understand I may need multiple treatments for the desired outcome.

10. I understand that exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times.

11. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation.

12. I release Blue Divine Aesthetics from these liabilities.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT:

Name of Adult Participant and/or Parent or Legal Guardian of Minor:

First Name:	TEST_CLIENTFIRSTNAME	Last Name:	TEST_CLIENTLASTNAME	Birth Date:	TEST_CLIENTBIRTHDATE
Address:	TEST_CLIENTADDRESS	City:	TEST_CLIENTCITY	Province:	TEST_CLIENTSTATE
Postal code:	TEST_CLIENTPOSTCODE	Email:	TEST_CLIENTEMAIL	Phone:	TEST_CLIENTPHONE

Date and Time Signed: 09/06/2016 at 16:06

System Time Stamp: 09/06/2016 at 20:06