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)

☐ Cancer	☐ Frequent cold sores	☐ Hepatitis
☐ Diabetes	☐ HIV/AIDS	☐ Hormone imbalance
☐ High blood pressure	☐ Keloid scarring	☐ Thyroid imbalance
☐ Herpes	☐ Skin disease/Skin lesions	☐ Blood clotting abnormalities
☐ Arthritis	☐ Seizure disorder	☐ Any active infection

Please answer the following questions:

Are you on any blood thinner medication such as heparin, coumadin, warfarin, etc.?	☐ Yes ☐ No
Do you have any cardiovascular problems?	☐ Yes ☐ No
Have you had any cortisone or steroid injections?	☐ Yes ☐ No
Have you had any cosmetic injections, filters or implants (i.e. Boxtox, collagen)?	☐ Yes ☐ No
Do you have eczema or psoriasis?	☐ Yes ☐ No
Do you have enlarged or painful glands?	☐ Yes ☐ No
Have you had facial waxing services performed within the past 7-14 days?	☐ Yes ☐ No
Do you have any heart ailments?	☐ Yes ☐ No
Do you have any inflammatory conditions?	☐ Yes ☐ No
Are you on any light sensitive medication?	☐ Yes ☐ No
Do you have loose, thin or aged skin?	☐ Yes ☐ No
Do you have any lymphatic disorders, inflammations of lymph vessels or lymph edema?	☐ Yes ☐ No
Do you have a pacemaker or metal implants?	☐ Yes ☐ No
Do you have phlebitis or varicose veins?	☐ Yes ☐ No
Have you been in a recent accident or had a serious injury?	☐ Yes ☐ No
Have you had a recent surgical or dental procedure?	☐ Yes ☐ No
Do you have rosacea or telangiectasia/couperose?	☐ Yes ☐ No
Do you have any skin abrasions or lesions?	☐ Yes ☐ No
Are you using any skin-lightening or bleaching agents?	☐ Yes ☐ No
Do you have a sunburn?	☐ Yes ☐ No
Do you have swollen or infected tonsils?	☐ Yes ☐ No
Are you under medical care for an existing or suspected condition or disease?	☐ Yes ☐ No
Do you have a viral infection or influenza?	☐ Yes ☐ 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 your 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 sin 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
	○	○	○	○	○
What is your natural hair color?	Red, sandy red	Blonde	Dark blonde chesnut,brown	Dark brown	Black
	○	○	○	○	○
What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	○	○	○	○	○
Do you have freckles on exposed areas?	Many	Several	Few	Incidental	None
	○	○	○	○	○

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 changed 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

Informed Consent for Hair Removal

Customer's name: **TEST_CLIENTFIRSTNAME TEST_CLIENTLASTNAME**

Treatment sites: (please check all that apply)

☐ **Mono-brow**	☐ **Arms**	☐ **Underarms**	☐ **Scrotum**
☐ **Lip**	☐ **Fingers**	☐ **Back**	☐ **Thighs**
☐ **Chin**	☐ **Chest**	☐ **Buttocks**	☐ **Lower Legs**
☐ **Neck**	☐ **Areola**	☐ **Bikini**	☐ **Feet**
☐ **Face**	☐ **Linea**	☐ **Labia**	☐ **Toes**

Combinations:

Previous hair removal methods:

☐ **Shaving**	☐ **Depilatories**
☐ **Tweezing**	☐ **Electrolysis**
☐ **Waxing**	☐ **Laser**

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3weeks.

Alternative methods are waxing, shaving, electrolysis, and chemical epilation.

The following problems may occur with the hair removal system:

1. There is a risk of scarring.

2. Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation (browning) **and Hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change is a rare risk**. Avoiding sun exposure before and after the treatment reduces the risk of color change.

3. Infection: Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.

4. Bleeding: Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.

5. 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.

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

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

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.

We have a 24 hour cancelation policy. You will be changed full price for all appointments that are a no show.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Blue Divine Aesthetics Staff, and specific technicians from all liabilities associated with the above indicated procedure.

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 16:05
System Time Stamp: 09/06/2016 at 20:05