Client Intake Consent Form

YOUNG MD
LASER & MEDICAL AESTHETICS

Name: _____ Date: _____
Birth Date: _____ Age: _____ Gender: _____
Phone: _____ Cell: _____ Email Address: _____
Street Address: _____
City, State, Zip Code: _____
Emergency Contact Information: _____
How did you hear about us? _____

Do you suffer from any of these conditions:

	Y/N		Y/N
Pigment Issues? (Hypo/Hyper Pigmentation)		Heart Disease	
Diabetes		Irregular Pulse	
Seizure Disorder (Epilepsy)		Fainting Spells	
High Blood Pressure		Asthma	
Polycystic Ovarian Syndrome		Keloid Formation/ Thick Scars	
Irregular Menses		Rosacea	
Thyroid Disorder		Lupus	
History of Cold Sores/ Fever Blisters		Hepatitis	
Acne		Chemotherapy	
Are you Sun Sensitive?		Skin Cancer	
Have you ever had a chemical peel, microdermabrasion, or resurfacing treatments		Are you currently using Retin A, Renova, Adapalene, or Tazorac? Have you used it in the past?	
Do you have tattoos/ permanent makeup		Have you ever taken Accutane?	
Have you ever had any laser treatment?		Cancer or other medical illnesses?	

Medications: Please list any medications you are currently taking including herbal supplements and vitamins.

What is your daily skin care regimen?

What topical medications or creams are you currently using? Do any of the following contain Glycolic Acid, Lactic Acid, or Hydroxy Acid?

Are you taking any mood altering medications? Y/N If yes, please explain.

Primary Physician:

Client Intake Consent Form Continued

History of Skin Cancer?

Drug Allergies: Please list any known Drug Allergies

Have you had any recent tanning, sun exposure or used tanning creams that have altered the color of your skin? Y/N

Do you smoke? Do you exercise regularly? Are you taking blood thinners?

Do you use sunscreen? Y/N What SPF? Do you scar easily? Do you heal quickly?

Have you had any of the following hair removal methods in the past six weeks? Please check all that apply

Shaving _____ Waxing _____ Electrolysis _____ Tweezing _____ Threading _____ Depilatories _____

Please mark any area(s) of interest:

Hair Reduction _____ Brown Spots _____ Wrinkles/Lines _____ Botox _____ Juvederm _____ Sagging Skin _____

Facial/Leg Veins _____ Skin Texture _____ Scarring _____ Fine Lines _____ Rosacea _____ Skin Hydration _____

Skin Lesions _____ Other Concerns _____

Describe your Ethnic Background/ Heritage (Where does your family hale from?)

Do you consider yourself sensitive to pain or touch?

Female Patients: Are you pregnant or trying to become pregnant? Breastfeeding?

I certify that the preceding medical, personal, and skin history statements are true and correct. I further understand that facials should not be construed as a substitute for a medical examination, diagnosis, or treatment, and that I should agree to see a physician or other qualified medical specialist for any physical ailment. Because a facial should not be performed under certain medical conditions, I am aware that it is my responsibility to inform the staff at O YOUNG MD Laser and Medical Aesthetics of my current medical and health conditions, and to update this history with any changes that may occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____

Physician Signature: _____ Date: _____