SenzaPeloMedSpa

Professionalism, Dedication, Kindness And Compassion

CLIENT PROFILE

Legal Name: _____ _____DOB: _____ _____Gender: _____

Preferred Name:_____ Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____--_____ Secondary Phone: (_____) _____--_____

E-mail Address (please print): _____

Who shall we thank for the referral?_____

In what services are you interested? __ Electrolysis __ Laser Hair Removal __ Electrodesiccation (blemish removal)

__ Aesthetic Nursing ((fillers & relaxers) __ Laser Rejuvenation __ Aesthetics __ IM Injections __ Permanent Makeup

Please Circle ALL "yes/no"

Would you like to receive our exclusive e-mail and text message promotions? (Please circle) YES NO

Medical Skin History

1. Do you have any permanent make-up or tattoos? **YES** **NO** Explain: _____
2. Have you recently prolonged sun exposure or artificial tanning within last four weeks *(all areas)*? **YES** **NO**
3. Are you currently using Retin-A/ Bleaching Agents? YES NO If yes, where was it applied? _____
4. Are you currently using or have you ever used Photosensitive medication such as Accutane? **YES** **NO**
   If yes, explain_____
5. Have you ever had microdermabrasion or chemical peel? **YES** **NO** If yes, how long ago? _____
6. Have you recently had facial surgery or laser resurfacing? **YES** NO If yes, how long ago? _____
7. Do you smoke? YES NO
8. Do you get cold sores/fever blisters? **YES** **NO** If yes, last breakout? _____
9. Are you sensitive to alcohol-based products? **YES** **NO**
10. List any items you are allergic/sensitive to: _____
11. Are you taking any other medications/ supplements/vitamins at this time? **YES** **NO**
    If yes, please list:

    _____
12. Do you have any medical conditions or autoimmune disorders? **YES** **NO**
    If yes, explain_____
13. Upcoming medical procedures **YES** **NO**

Medical Hair History

Area(s) to be treated:_____

_____

1. Are you pregnant? **YES** **NO** Are you lactating? **YES** **NO**
2. Are you in or past menopause? **YES** **NO**
3. Do other family members have excessive hair? **YES** **NO** Relationship _____
4. Please list previous/current methods of hair removal _____
   How often are you using hair removal: _____ Last time you removed your unwanted hair _____
5. List previous laser/electrolysis treatments: First treat. date: _____ Last treat. date _____
   Electrolysis modality: Thermolysis _____ Blend _____ Galvanic _____Laser Type

_____

Patient Signature: _____Date:_____

SenzaPeloMedSpa

Professionalism, Dedication, Kindness And Compassion

PATIENT ANESTHESIA RELEASE FORM

Please fill out the following information and sign this form in the space provided. Thank you.

Name: _____ Date of Birth: ____/_____/____ Weight: ___(lbs) Height: __'___"
(Please print your full name clearly and legibly)

Person to Contact in case of emergency:_____

Phone Primary Number: (____) ____-_____ Secondary Number: (____) ____-_____

PATIENT MEDICAL INFORMATION

Have you ever received anesthesia before? Yes: ___ No: ___
Did you have any type of reaction to the anesthesia? Yes: __No: __

If "Yes", explain: _____
_____
_____
_____

When did this occur? (Month/Day/Year): _____

Where did this occur? Hospital: _____ Doctor's Office: _____

List the type or types of anesthesia you to which you've had a reaction or may have had a reaction to:

A) _____
B) _____

Do you have any health problems in the areas that could be affected by your receiving anesthesia?

Heart: _____	Diabetes: _____	HIV/Aids: _____	Alcohol: _____
Breathing: _____	Cancer: _____	Hepatitis: _____	Depression: _____
Kidney: _____	Bleeding: _____	Stomach: _____	STD: _____
Blackouts: _____	High Blood Pressure: _____	Are you pregnant: _____	

Do you smoke or use tobacco products? Yes: ___No: __ How many cigarettes per day? __

How much tobacco product per day? _____ Do you have any allergies? please list below

_____

Are you on any form of prescribed medication at this time? Yes: ___ No: ___

List any medication you are now taking:

A) _____
B) _____
C) _____
D) _____

PATIENT ANESTHESIA RELEASE FORM
(CONTINUED)

List any other medical problems of which you are or may be aware:

A) _____
B) _____
C) _____
D) _____
E) _____

I, _____, *(Please print your full name clearly and legibly)* fully

understand that my blood pressure may be elevated and my heart rate may increase due to the local injection of Lidocaine and Epinephrine. There may be local redness and swelling for up to four hours post injection. To the best of my knowledge, the information provided on this Release Form is true and accurate.

I understand that I will assume full responsibility for any side effects due to inaccuracy or failing to provide any information on my part which might cause injury to occur from the administration of anesthesia for the personal elective procedures that I am about to receive at this clinic and/or facility. Furthermore, I will not hold responsible the Registered Nurse (or the person administering anesthesia) for any malpractice procedures not directly related to receiving anesthesia that I might receive at this clinic and/or facility. In addition, I have been fully briefed by the Registered Nurse as to what side effects I can expect from the anesthesia that I receive and will comply fully with all instructions given to me. In the event that I find I cannot comply with all or part of the instructions given to me by the Registered Nurse, I will not fully or partially hold the Registered Nurse responsible either legally, morally, mentally, physically, or ethically, nor will I seek compensation in any form from said Registered Nurse because of my own negligence in complying with instructions or other procedures given at this facility. I also understand that the Registered Nurse is not associated with (nor responsible for/nor liable for) any other motions, procedures, comments, attitudes, and recommendations administered by or conveyed by any other person or persons working or using this facility for any purpose, treatment, assistance, or any other procedure.

Signature: _____ Date: _____