

Patient Questionnaire

Name: _____ Age: _____ Date of Birth: ___/___/___ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail: _____ How did you hear about Iatria? : _____

In case of emergency, whom should we contact? _____ Phone: _____

Medical History

Have you ever had (please check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye conditions |
| <input type="checkbox"/> Heart attack or chest pain | <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Delayed or abnormal wound healing | <input type="checkbox"/> Endocrine or hormone disorder |
| <input type="checkbox"/> Heart pacemaker or defibrillator | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Current or recent pregnancy |

List any active medical problems you have: _____

List any medications you currently take: _____

List any medication allergies you have: _____

Are you allergic to any metals?: _____ Are you allergic to latex? _____ Do you use any tobacco products?: _____

Surgical History

List any operations you have had:

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Dermatologic History

Have you ever had (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic skin conditions | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Laser skin resurfacing |
| <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Herpes simplex or cold sores | <input type="checkbox"/> Chemical peel |
| <input type="checkbox"/> Keloid or hypertrophic scar | <input type="checkbox"/> Accutane use for acne | <input type="checkbox"/> Botox® injection |
| <input type="checkbox"/> Pigmentation disorder | <input type="checkbox"/> Tetracycline use for acne | <input type="checkbox"/> Injection of collagen or other dermal filler |
| <input type="checkbox"/> Recent waxing or plucking | <input type="checkbox"/> Electrolysis or threading | <input type="checkbox"/> Recent sunburn or tan (include tanning bed) |

What is your ethnic background?: _____

When exposed to the sun, do you usually: Always burn, never tan Burn easily, tan poorly Tan after initial burn
 Burn minimally, tan easily Rarely burn, tan darkly easily Never burn, always tan darkly

Do you use sunscreen regularly?: _____ Do you use artificial or "sunless" tanning products?: _____

List any special skin care products you use: _____

Patient Signature: _____

Date: _____

Parent or Guardian (if Patient is under 18 years of age): _____

Provider: _____

Date: _____

INFORMED CONSENT FOR MEDICAL GRADE PEELS

Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as pregnancy, recent facial peels or surgery, allergies, tendencies to cold sores and fever blisters, use of Retin-A, Accutane or Hormones, and recent or upcoming exposure to ultraviolet rays (sun or tanning beds).

I understand there may be some degree of minor discomfort, i.e. itchiness, redness.

I understand there are no guarantees to this procedure.

I understand that to achieve maximum results, I will need several ongoing treatments and use a daily product over a period of time, including sunscreen.

I understand that the possibility of irritation and redness exists and that I should notify my skin care professional when irritation persists.

I understand that I can not have this procedure if I have any sunburn, or have been recently exposed to the sun preceding this procedure. I understand that I will not expose myself to the ultraviolet rays (sun or tanning beds) after this treatment for at least 48-72 hours.

I will follow the home care program specifically designed for me without changing or adding any products without consulting my skin care professional.

I agree to all the above to have this treatment performed on me and will follow all prescribed directions regarding post peel care.

I voluntarily consent and authorize that this medical grade peel treatment be performed by the staff of this facility, including physicians, nurse practitioners, estheticians, associates and any other health care providers as deemed necessary. I hereby release this facility, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.

Signature _____ Date _____

Parental or Legal Guardian Signature Required if Under 18 Years of Age

Skin Care Questionnaire

Date: _____
Name: _____ Birthdate ___/___/___
Address: _____ City: _____ State: _____
Zip Code: _____ Home Phone: _____ Work Phone: _____
Referred By: _____

Personal Data

Smoker ___ No ___ Yes
Pregnant ___ No ___ Yes
Cosmetic Surgery ___ No ___ Yes, When _____ Describe _____
Medication ___ No ___ Yes What Kind? _____
Any Health Problems? ___ No ___ Yes Explain _____
Any Allergic Reactions To Medication? ___ No ___ Yes Describe _____
Do You Have Any Allergies? ___ No ___ Yes
Do You Suntan? ___ No ___ Yes
Do You Use Sunscreen? ___ No ___ Yes What SPF? _____

Please Name the Brand of Products You Are Currently Using:

Cleanser _____ Toner _____ Moisturizer _____
Scrub _____ Mask _____ Other _____

Have You Ever Used Retin-A? ___ No ___ Yes When? _____

Have You Ever Been Treated With Phenol or Trichloroacetic Acid (TCA)? ___ No ___ Yes When? _____

Have You Ever Used Hydroquinone? (Skin Lightener) ___ No ___ Yes

Have You Ever Been On Accutane? ___ No ___ Yes ___ When? _____

Have You Ever Had Any Of The Following: (Circle If Applies)

Herpes _____ Hives _____ Cold Sores _____ Fever Blisters _____ Keloids (raised scars) _____
When? _____

Would You Characterize Your Skin As:

Sensitive _____ Rough _____ Dry _____ Oily _____

If You Had A Complaint About Your Skin, What Would It Be? _____

What Is Your Most Important Skin Care Goal? _____

MICRODERMABRASION CONSENT FORM

PRE- MICRODERMABRASION INSTRUCTIONS

Contact lenses cannot be worn during Microdermabrasion therapy. Please make sure they are removed prior to your appointment.

Those who have completed a course of Accutane within one year are not candidates for Microdermabrasion

Resolution of open lesions, active cold sores, acute facial dermatitis, or facial irritation should be achieved prior to receiving Microdermabrasion therapy.

Recipients of a phenol peel or any deep peel within the last two years are not candidates for Microdermabrasion.

Microdermabrasion can provide marked improvement in the appearance of one's skin. Therefore, it is very important that you have a thorough understanding of what Microdermabrasion can and cannot do for your particular skin condition. In addition, it is imperative that you acknowledge the potential risks associated with Microdermabrasion.

Before undergoing Microdermabrasion, carefully read the following statements. After you have read each statement, please initial each respective statement in the space provided.

_____ I understand that the practice of medicine is not an exact science, and therefore results cannot be guaranteed. I acknowledge that no guarantee has been given to me as to the condition of my skin or degree of improvement expected following treatment.

_____ I understand that multiple treatments and the use of home care products are required to achieve optimal results. I will follow the home care regimen specifically designed for me without changing or adding any products. I understand that if I experience any adverse side effects that appear to be attributable to my use of home care products, I would discontinue use of the products and notify the office immediately.

_____ I understand that there are potential risks and complications that may require further treatment. These include but are not limited to: Discomfort, changes in pigmentation, swelling of the area treated, scarring, infections, blistering, scratchiness, bruising, itchiness, and redness.

_____ I agree to follow all post-Microdermabrasion instructions.

_____ I consent to the photographing of the operation or procedures to be performed. These photographs can be taken at any point in my medical management as is considered necessary for my medical records. The photographs may be used in the interest of medical education for allied medical personnel and laypersons. Identifying features may be visible, but I shall not be identified by name.

I, _____ hereby declare that I have read and fully understand the above consent. I have been fully informed regarding associated risks of Microdermabrasion and alternative treatments. All of my questions have been answered in a satisfactory manner.

Patient Signature

Date

Witness

Date

POST MICRODERMABRASION INSTRUCTIONS

You may resume your daily activities or return to work immediately.

Your skin may feel extra sensitive. It is normal to see a little redness or have a “windburn” sensation for part of the day.

Unless recommended by our office, do not have a chemical skin peel procedure performed during the next two weeks.

A moisturizer will be applied to the treated area before you leave the office. Continue to use your moisturizer on a daily basis.

Minimize sun exposure. Sun block will be applied to the treated area before you leave the office. Protect your face every day with a high-quality broad-spectrum sun block with Titanium Dioxide, Zinc Oxide, or Parsol 1789.

For 24-48 hours after your treatment, no glycolics, alpha hydroxy, beta hydroxy, topical vitamin C, Retin-A, benzoyl peroxide or topical acne medications are to be applied to the treated areas. You will be advised when to reintroduce your skin care products.

Mineral Makeup can re-applied immediately if desired.

IATRIA MEDSPA QUALITY SURVEY

To Our Dear Patient,

Your comfort, care, and happiness are of paramount importance to us. In order to ensure that we offer the absolute best service that we possibly can, we are in need of your valuable input. Would you please take a few moments to complete the following survey and return it to us to ensure that we provide you and our other patients with the highest quality care possible?

Patient name (optional):

Date of your treatment or service:

How did you hear about **Iatria** Medspa?

Did you use a promotional coupon? Yes No If so, which one?

How did you find your visit with us overall? Excellent Good Fair Poor

Were you made to feel welcome upon your arrival? Yes No

Were you seen in a timely fashion? Yes No If no, please explain below

Was your privacy maintained at all times? Yes No

Was the temperature of the facility comfortable? Yes No

Were you offered refreshments? Yes No

If yes, were these satisfactory? Yes No

If you experienced any discomfort with the treatment, was it well controlled? Yes No

Were you offered the opportunity to purchase any skin care products? Yes No

If yes, did you purchase any? Yes No If yes, which did you purchase?

Do you have any comments about your skin care products?

Would you recommend **Iatria** Medspa to other people? Yes No

Would you visit **Iatria** Medspa again in the future? Yes No

Do you have any additional comments?