Medical History

Patient Name:_____ **DOB:**_____

Primary Care Physician/phone number: _____

In case of Emergency, who should be notified? (Name and Phone)

_____

Unless otherwise indicated, we have permission to communicate changes in your health status, including surgery, to other physicians participating in your care. [ ] Yes, may notify [ ] No, please do not notify.

Do you have any major medical problems, serious illness? [ ] Yes [ ] No If yes, please list:

_____

_____

Please list all prior surgical procedures and dates performed:

_____

_____

Please list all injectable procedures (Botox, Juvederm, Restylane, Collagen, etc.) and dates performed:

_____

_____

MEDICAL HISTORY_____

Do you have a pacemaker or defibrillator? [ ] Yes [ ] No
Do you suffer from "photosensitivity" (extreme sensitivity to sunlight)? [ ] Yes [ ] No
Do you have a history of easy/excessive Hyperpigmentation? [ ] Yes [ ] No
Do you form keloid scars? [ ] Yes [ ] No
Do you suffer from seizures? [ ] Yes [ ] No
Do you have any metal implants? [ ] Yes [ ] No
Do you wear contact lenses? [ ] Yes [ ] No
Have you taken Accutane, Retin A or Renova in the past 12 months? [ ] Yes [ ] No
Are you currently taking Coumadin (Warfarin) or other blood thinners? [ ] Yes [ ] No
Do you require antibiotics before procedures such as dental cleanings? [ ] Yes [ ] No
Do you smoke? [ ] Yes [ ] No If yes, packs per day? _____
Do you drink alcohol? [ ] Yes [ ] No If yes, how many drinks per week? _____
Have you ever had an adverse reaction to laser or cosmetic treatments? [ ] Yes [ ] No If so, please list:

_____

Are you allergic to any medications? [ ] Yes [ ] No If so, please list:

_____

Do you have any other allergies? [ ] Yes [ ] No If so, please list:

_____

Do you take any of the following (please check all that apply and/or list additional medications):

[ ] Antibiotics
[ ] Anti- coagulants
[ ] Appetite depressants
[ ] Aspirin or Ibuprofen
[ ] Blood Pressure Medication
[ ] Cortisone or Steroids
[ ] Hormones/ contraceptives
[ ] Insulin
[ ] NSAIDS
[ ] Sedatives
[ ] Thyroid medication
[ ] other_____

Are you taking herbal preparations or vitamins (St. John's Wort, Vitamin E, etc.)? [ ] Yes [ ] No
Are you or might you be pregnant? [ ] Yes [ ] No
Are you trying to become pregnant? [ ] Yes [ ] No
Are you nursing? [ ] Yes [ ] No
Have you ever had any problems with any of the following anesthetics? If so, please specify:
[ ]Block (e.g. dental): Ineffective / Heart palpitations / Systemic reaction/ Other _____
[ ]Local: Ineffective / Heart palpitations / Systemic reaction / Other _____
[ ]Topical: Ineffective / Heart palpitations / Systemic reaction / Other _____

Have you ever had or do you have any of the following (please check all that apply):

[ ] Active Infection	[ ] Asthma	[ ] Bleeding Disorders
[ ] Blistering sunburns	[ ] Circulation Problems/ Blood Clots	[ ] Cold sores/ Shingles
[ ] Collagen disorder	[ ] Diabetes (type_____)	[ ] Easy Bruising
[ ] Exzema	[ ] Endorcrine / Hormonal Issues	[ ] Eye Problems
[ ] Fatigue	[ ] Fibromyalgia	[ ] Headaches / Migraines
[ ] Heart Condition	[ ] Hepatitis	[ ] High / Low Blood Pressure
[ ] HIV/AIDS	[ ] Hormonal Imbalance	[ ] Insomnia / Sleeping Problems
[ ] Joint Injury	[ ] Multiple Sclerosis Muscle Pain / Spasms	[ ] Neurological Disorders
[ ] Permanent Makeup / Tattoo	[ ] Pigmentation Disorders	[ ] Psoriasis
[ ] Melanoma	[ ] Recent Surgery	[ ] Scleroderma
[ ] Sensitive Teeth	[ ] Skin Cancer	[ ] Skin Injury
[ ] Stroke	[ ] Unusual Moles	[ ] Varicose Veins
[ ] Vision Deficits	[ ] OTHER _____	

SKIN CARE HISTORY AND CONCERNS

Please list any products that irritate your skin:

_____

_____

Have you had unprotected sun exposure or been in a tanning booth in the last 2 weeks? [ ] Yes [ ] No
Do you use self-tanners? [ ] Yes [ ] No If yes, when was last application? _____
Are you planning a vacation in the sun in the next 3-6 months? [ ] Yes [ ] No
Have you used any of the following hair removal methods in the past 6 weeks? [ ] Shaving [ ] Waxing [ ] Electrolysis [ ] Plucking/Tweezing [ ] Stringing [ ] Depilatories

Please indicate your current skin care products/regimen:

_____

_____

_____

ACKNOWLEDGEMENT OF PRACTICE POLICIES

I understand that I will receive traditional spa or cosmetic medical treatment from *McRae MD Medical Laser Spa*. Some of the various treatments *McRae MD Medical Laser Spa* provides include: Facials, microdermabraison; Botox® Cosmetic/Xeomin injections and filler injections, Microneedling with PRP, and Various Lasers.
I understand that depending on the treatment I select, I will be required to sign an informed consent specific to that treatment.

_____ (Please Initial)

I am fully aware that my condition is solely of a cosmetic nature and that the decision to proceed is based on my expressed desire to do so:

_____ (Please Initial)

Payment Policy I understand that my treatments at *McRae MD Medical Laser Spa* require payment and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by *McRae MD Medical Laser Spa*. For cosmetic medical procedures, I understand that the services often require more than one session for best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There is no guarantee of refunds on treatments paid in advance. Any refunds will be determined on a case by case basis after appropriate management approval. I further understand that the services offered by *McRae MD Medical Laser Spa* are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, check or most major credit cards.

_____ (Please Initial)

Cancellation, Late Policy I am aware that *McRae MD Medical Laser Spa* requires 24 hours notice of a cancellation and that it is my responsibility to provide timely notice by calling *McRae MD Medical Laser Spa*. I agree to pay a $25.00 fee if I fail to give the required 24 hours notice. If I have prepaid my treatment session or sessions, I understand that I may forfeit one of my future sessions if I do not provide *McRae MD Medical Laser Spa* with the required 24 hours notice.

_____ (Please Initial)

The *McRae MD Medical Laser Spa* asks that I arrive 15 minutes prior to each of my scheduled appointment time(s) so that all appointments can run both efficiently and timely. Late arrivals may result in a reduction of treatment time or appointment being rescheduled, along with a cancellation fee of $25.00 if appointment has to be rescheduled.

_____ (Please Initial)

Return Policy All sales of skin care and supplements are final. Unopened products may be returned with a receipt for a credit within 30 days. If you have a reaction from a product must notify *McRae MD Medical Laser Spa* within 24 hours of reaction, we will give you Store Credit. Lasers or Services you cannot transfer for trade of product.

_____ (Please Initial)

ACKNOWLEDGEMENT OF PRACTICE POLICIES

Disclaimer I understand that all medical cosmetic treatments are provided exclusively by *McRae MD Medical Laser Spa*. I will not hold *McRae MD Medical Laser Spa*, its owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that *McRae MD Medical Laser Spa* cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion.

_____ (Please Initial)

I understand that even with the best products, equipment, and the highest trained technicians, as high as 10-15% of patients will not have a desired response/outcome to treatments.

_____ (Please Initial)

Privacy I have received a copy of the *McRae MD Medical Laser Spa* Notice of Privacy Practices.

_____ (Please Initial)

I certify that the above statements of my Medical History are true and correct and that I have been fully advised concerning the nature of the proposed treatments to be administered.
I do here by authorize and direct *McRae MD Medical Laser Spa* **to administer such procedures as may be deemed elective.**
I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent:

My signature below constitutes my acknowledgement that:

1) **I have read, Understand and fully agree to the foregoing consent**
2) **I hereby give my consent and authorization and release** *McRae MD Medical Laser Spa* **and its agents of any future claims that I may have in connection with the described treatments that I receive.**

Print Patient Name: _____

Patient Signature: _____ Date: _____

I have explained the above statements to the client and answered all questions.

Staff Name: _____

Staff Signature:_____ Date: _____