# MEDICAL HISTORY FORM

Name_____Home Phone _____

Address _____Cell Phone _____

City_____ State _____Date of Birth _____

Zip Code_____ DL#_____ Sex __ M __ F Age _____ SS# _____

Patient's Employer_____Occupation _____

Employer's Address_____Work Phone_____

City_____ State_____Zip Code _____

Any other family members who have been treated here? __ Yes __ No Name _____

Provider you see at Plano Dermatology _____

Email: _____ I consent to this email address being added to the Skinnovations email list, where I will receive information on special promotions ☐ yes ☐ no

## RESPONSIBLE PARTY

Name of Responsible Party_____Date of Birth_____

Address_____ Home Phone_____

Relationship: Husband/Wife/Father/Mother/Son/Daughter _____ Occupation_____

Employer_____Work Phone_____

Employer's Address_____

City_____ State_____Zip Code _____

## IN CASE OF EMERGENCY CONTACT

Name_____ Relationship_____

Address _____ Telephone _____

Our Notice of Privacy Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by requested from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We re not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this Form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as though original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

_____ _____

Signature Date

Skinnovations Medical Esthetics at Plano Dermatology

# Personal Profile and Health History

How did you hear about us _____

Please list the purpose of your visit _____

_____

_____

Please specify your genetic origin: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Mediterranean ☐ Middle Eastern ☐ Native American ☐ Other

| | | | |
|---|---|---|---|
| **Females only:** | Could you be pregnant? | Y | N |
| | Are you currently pregnant or breastfeeding? | Y | N |
| | Are you planning pregnancy during course of treatment? | Y | N |
| | During pregnancy did you develop hyperpigmentation or masking? | Y | N |
| | Do you have regular periods? | Y | N |
| | Are you going through menopause? | Y | N |

What brand of skin care products are you currently using:

Cleanser_____ Toner/Astrigent _____
Moisturizer_____ Eye Cream_____
Exfoliator _____ Make-up_____
Sunscreen_____ Other_____
Topicals prescribed by a physican_____

Please list any products that irritate your skin _____

_____

**Medical History (Please check all that apply)**

☐ Bleeding Disorders
☐ Botox / Dysport / Fillers
☐ Burns / Skin grafts
☐ Cold Sores / Fever Blisters
☐ Diabetes
☐ Epidermolysis Bullosa
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ Hirsutism
☐ HIV
☐ Hormone Replacement Rx
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Implants Where _____
☐ Keloid Scars
☐ Lupus Erythematosus
☐ Pacemaker
☐ Permanent Makeup
☐ Polycystic Ovary Disease
☐ Port-Wine Stain
☐ Psoriasis
☐ Rosacea
☐ Seizures
☐ Skin Cancer Where_____
☐ Tattoos
☐ Vitiligo

Any other disorder not listed above _____

Present Health Concerns:_____

_____

## Medical History

Are your presently receiving medical treatment for any condition(s)? ❑ Yes ❑ No

*If yes please list condition(s)*

| Condition | How Long |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Medications

*Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills, and herbs:* ❑ None

| **Medication** *(including strength)* | How many times a day | How long taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are you taking any blood thinning medications? *(If yes, please list below)* ❑ Yes ❑ No

_____

## Allergies

Are you allergic to any medications? *(If yes, please list below)* ❑ Yes ❑ No

| Allergic to: |
|---|
| Skin allergies? *(If yes, please list below)* ❑ Yes ❑ No |
| |

**Please answer the following questions** **Circle One**

Have you been on antibiotics in the last 2 weeks? Y N
Have you ever taken accutane? When _____ Y N
Have you ever seen a physician regarding your skin? If so, who _____ Y N
Do you have any active skin diseases or infection in the area being treated? Y N
If yes, please list: _____
Are you allergic to latex, lidocaine, or any lotions? Y N
Have you had any previous laser treatments/ skin treatments to the area being treated? Y N
If yes, please describe: _____
Are you using a prescription Retinoid? (Retin-A, Differin, Tazorac, Tretinoin, etc) Y N
Are you using glycolic/AHA or Salicylic BHA home care products? Y N
Do you or have you ever smoked cigarettes or cigars? Any tobacco use? Y N
Do you sunbathe? _____ Do you burn or tan? _____
If yes, approximate date of last sun exposure? _____
Are you currently using or have you used a tanning bed or self-tanner? Y N
If yes, approximate date of last use? _____
Do you use a sunscreen? _____ What brand _____
Summer _____ SPF _____ Winter _____ SPF ____ Y N

Do you thread, tweeze, and use depilatories or hot wax? Y N
Does your skin remain discolored after healing from a cut? Y N

Have you **EVER** had a COLD SORE? ☐ yes ☐ no If so, when was your last cold sore _____

I feel like my skin is: X-Dry____ Dry____ Normal____ Combination____ Oily____

**Please indicate which of the following concerns you have about your skin?**

| | | | |
|---|---|---|---|
| ☐ Acne | ☐ Hair Removal | ☐ Redness | ☐ Texture |
| ☐ Aged Skin | ☐ Isolated Fat Areas | ☐ Rosacea | ☐ Uneven Skin Color |
| ☐ Age Spots | ☐ Leg Veins | ☐ Scarring | ☐ Whiteheads |
| ☐ Blackheads | ☐ Melasma | ☐ Sensitive Skin | ☐ Wrinkles |
| ☐ Enlarged Pores | ☐ Milia | ☐ Stretch Marks | |
| ☐ Facial Veins | ☐ Pigmentation | ☐ Sun Damage | |

**I confirm that the answers to the questionnaire are true and correct.**

_____ Date: _____
Signature of Patient:

_____ Date: _____
Signature of Patient's Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
Reviewed by Medical Director/Nurse Practitioner/Physican

# *Skinnovations*
# *Medical Esthetics*

## Policy and Procedure Agreement
***Effective February 1, 2017***

### *Cancellation Policy:*

- **Cancellations or Reschedules:** If you are unable to make your appointment, please call (214) 615-7866 to cancel or reschedule **24 hours** before your scheduled appointment time.
- **Late for Scheduled Appointments:** If you are 15 minutes or more late, you have **"Missed"** your scheduled appointment time and will have to re-schedule.
- **Appointments Not Canceled 24 hours in Advance/Late/ No Shows:**
  **1st Occurrence** you will be given a verbal and/or written warning.
  **2nd Occurrence** you will be billed $50.00 to compensate the loss of revenue from the staff member, room and equipment that was reserved for you.
  **3rd Occurrence you** will be dismissed as a patient of Skinnovations Medical Esthetics and will no longer be allowed to schedule appointments with us.

**We realize that life happens and exceptions may be made due to unexpected or uncontrollable circumstances if approved by management. We are striving to better serve you and appreciate your understanding and cooperation.**

### *Pre-Purchased Treatments:*
All pre-purchased (individual or package) treatments must be used within 12 months of purchase date. If other arrangements are not made before the 12-month expiration, you will forfeit your pre-paid treatments.

### *Treatment Packages:*
Treatment packages can only be used by the patient the package was purchased for. We will not split treatments between patients or transfer treatments to another patient.

### *Return or Exchange Policy:*
All products must be returned or exchanged within 30 days of purchase date.

### *Birthday Discounts:*
Birthday discounts only apply to you, and are only eligible during the month of your birthday**.**

### *Payment Policy:*
Payment must be paid in full at time of service.

**All product and procedure pricing are subject to change without notice.**

**A copy of our Policy and Procedure Protocol can be provided to you upon your request.**

**Patient Signature** _____ **Date** _____

**Parent or Guardian Signature** _____ **Date** _____