PATIENT MEDICAL HISTORY & SKIN EVALUATION FORM

In order to provide you with the most appropriate treatment plan, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Patient Name:___________________________ Date of Birth:_______________ Today's Date:____________

Which of the following best describes your skin type? (Please circle one number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, describe:

____

Are you currently under the care of a dermatologist? Yes No

If yes, describe:

____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Have you had or currently have any of the following medical conditions? *(Please check all that apply)*

Cancer	Diabetes	High blood pressure	Herpes
Arthritis	Cold sores	HIV/AIDS	Keloid scarring
Skin disease/lesions	Seizure disorder	Hepatitis	Hormone imbalance
Thyroid imbalance	Any active infection	Blood clotting abnormalities	Heart Problems
Hernia	Rosacea	Eczema	

Do you have any other health problems, skin conditions or sensitivities?

Please list and describe in detail:

____

____

Have you ever had an allergic reaction to any of the following, including medications and any skin care ingredients? (Please check all that apply and describe the reaction you experienced)

Food	Latex	Aspirin	Hydroquinone/skin bleaching agents
Lidocaine	Ultrasound Gel	Baby Oil	Hydrocortisone/Steroid Creams

Others:

Type of Reaction:

Please list any medication allergies:

MEDICATIONS

What oral medications are you currently taking? Birth control pills Hormones
Others (Please list):

Have you ever taken Accutane? Yes No
If yes, when did you last take it?

What topical medications or creams are you currently using? Retin-A® Other

(Please list):

What herbal supplements do you use regularly?

HISTORY

Have you ever had any neurotoxins (Botox/Dysport) or fillers? Yes No
If yes, please list date, area, and describe treatment:

Have you ever had a thread lift? Yes No
If yes, please list date and treatment area:

Have you ever had any laser treatments, IPL, microneedling, or chemical peels? Yes No Other
If yes, please list date and describe treatment:

Have you ever had any cosmetic or reconstructive surgery on the face or body? Yes No
If yes, please list date and describe treatment:

Have you used any of the following hair removal methods in the past six weeks? *Circle: FACE / BODY*

Shaving Waxing Electrolysis Laser Hair Removal
Threading Depilatory Tweezing Other: ____________

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Do you use a tanning bed? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Have you ever had any permanent makeup done, such as microblading or lip blushing? Yes No
If yes, please describe:

____

Have you been diagnosed with Melasma? Yes No

Do you commonly get breakouts? Yes No How Often:

____

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) after an injury/wound? Yes No
If yes, please describe:

____

Do you have a pacemaker, heart monitor, or ANY metal implants: Yes No
If yes, please describe and include location of metal implant:

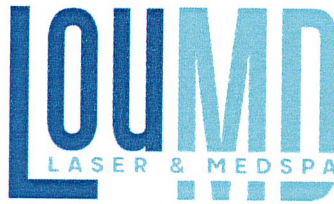
____

For our female clients:
Are you pregnant or trying to become pregnant? Yes No
Are you breastfeeding? Yes No

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, doctor, or nurse of my current medical or health conditions. If any of my information changes throughout the course of treatment or care, I will inform my provider of these changes. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: ____ Date: ______________

Witness Signature: ____ Date: ______________



REFUND POLICY

LouMD Medspa does not issue refunds for any service that was purchased, including pre-paid services/packages. However, to ensure our patients always have a pleasant experience at LouMD Medspa, unused or remaining treatments may be transferred to another service or applied as a medspa credit to your account.

During your consultation, we will discuss treatment options, benefits, and risks associated with each treatment so that each patient can choose the approach that is best suited for their needs and budget. It is virtually impossible to predict results and therefore payments made for services are for treatments to be performed -- not for a specific result. However, we always strive to achieve the absolute best result that we can for you.

RESCHEDULE, CANCELLATION, AND NO-SHOW POLICY

_______*(Initials)* We require a 48-hour notice if you need to cancel or reschedule your appointment. You may call the office directly or leave a message with the answering service to do so. As a courtesy, we confirm appointments via email, text, and/or call a week before and the day prior to scheduled appointments. Please understand that when you forget to cancel or reschedule your appointment without giving proper notice, another patient loses the opportunity to be seen and receive service.

In the event we do not receive the required **48-hour notice for rescheduling and cancellations**, a $50 fee will be applied to your card or will be collected at your next appointment if your card declines. This $50 fee also applies to no-show appointments.

All new and established patients will be required to provide a credit card to have on file. All cards on file are added to the system via a secure electronic process the ensures the information is encrypted and remains secure.

LATE POLICY

We understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if that ever occurs, so we can do our best to accommodate you. **If you arrive more than 10 minutes late to your appointment, your appointment may be cancelled and rescheduled.** We want to make sure we provide you with quality treatment without impacting other patient appointments.

_______*(Initials) In the event a patient has a history of showing up late to two or more appointments, a patient may be subject to a $50 late fee for future late arrivals per management's discretion.*

I have read and understand the above policy and accept its terms and obligations.

Signature: ____ Date: _________________

Signature of Witness: _____________________________________ Date: _________________