pelle
— spa

Medical, dermatologic and personal history questionnaire

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

Full Name _____ Age _____ Date _____

Street Address _____ City _____ State _____ Zip _____

Date of birth _____ Occupation _____

Email address _____ Primary phone _____

Full name and phone number of your emergency contact _____

How did you hear about us? Check all that apply. (Select any or none)

☐ From a friend ☐ Internet search ☐ Social media (e.g. Facebook) ☐ Email message ☐ Billboard ☐ Digital sign ☐ Other:_____

SKIN TYPE

Please describe your ethnicity _____

Which of the following describes your skin type? (Pick one)

☐ Always burn, never tan ☐ Always burn, sometimes tan ☐ Sometimes burn, always tan ☐ Rarely burn, always tan ☐ Never burn, always tan ☐ Black skin

How often do you use sunscreen? (Pick one) ☐ Every day ☐ Most days ☐ Only when I expect to be outside ☐ Only for certain activities ☐ Rarely ☐ Never

Do you use tanning beds? (Pick one) ☐ Yes, I am currently using a tanning bed regularly. ☐ Yes, within the last 6 months. ☐ Yes, but it has been more than 6 months. ☐ No.

Have you recently used self-tanning treatments? (Pick one) ☐ Yes, I am currently using a self-tanning treatment regularly. ☐ Yes, within the last 6 months. ☐ Yes, but it has been more than 6 months. ☐ No.

MEDICAL HISTORY

Are you currently under the care of a physician or dermatologist? (Pick one) ☐ No ☐ Yes - physician ☐ Yes - dermatologist ☐ Yes –both Please explain any affirmative answer to the above question.

_____

Do you have any of the following (Select any or none) ☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Active infection ☐ HIV/AIDS ☐ Frequent cold sores ☐ Keloid scarring ☐ Seizure disorder ☐ Hepatitis ☐ Hormone imbalance ☐ Arthritis ☐ Thyroid disease ☐ Allergies ☐ Blood clotting abnormalities ☐ Skin disease ☐ Herpes Please explain any of the above you selected.

_____

Do you have any other chronic medical conditions? If so, please explain._____

_____

Do you use tobacco products? (Pick one) ☐ No ☐ Yes, I currently smoke, chew, or otherwise consume tobacco ☐ No, but I did in the past If you are a current or former smoker, please describe the duration and quantity.

_____

Have you ever had an allergic reaction to any of the following? (Select any or none) ☐ Lidocaine ☐ Hydrocortisone ☐ Hydroquinone or skin bleaching agents ☐ Sun ☐ Food ☐ Latex ☐ Aspirin

If so, please explain the reaction _____

Please list all current medications including over-the-counter and herbal medications

_____

Please list all topical creams you are currently using

_____

Please describe any past skin treatments and, if applicable, any reactions

_____

Have you ever used Accutane (Isotretinoin)? (Pick one) ☐ Yes, I am currently using Accutane. ☐ Yes, within the last 6 months. ☐ Yes, but it has been more than 6 months. ☐ No.

Have you ever had laser hair removal? (Pick one) ☐ Yes, I am currently undergoing laser hair removal treatment. ☐ Yes, within the last 6 months. ☐ Yes, but it has been more than 6 months. ☐ No.

Which, if any, of the following hair removal methods have you used in the previous six weeks? (Select any or none) ☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Tweezing ☐ Stringing ☐ Depilatories ☐ None

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) after physical trauma? (Pick one) ☐ Yes ☐ No If you answered yes to the above question, please explain in detail.

_____

FOR OUR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? (Pick one) ☐ Yes ☐ No ☐ NA - male

Are you breastfeeding? (Pick one) ☐ Yes ☐ No ☐ NA - male

Date of last menstrual period. _____

IMPORTANT POLICIES AND PROCEDURES

☐ I understand that cancellations must be made prior to appointments. I understand I must cancel 24 hours prior to my scheduled appointment or I will be charged $25.00 for every missed appointment. I understand that laser treatments are nontransferable.

☐ I give permission for photographs taken of all treated sites to be used for the medical record, and anonymously for teaching, illustration in scientific papers or for marketing and/or literature. I agree to follow up at recommended intervals to assess my status and to inform Pelle Spa, LLC of any problems that I may be having and allow examination at that time.

☐ By completing this form, I agree to notify Pelle Spa if I become pregnant, start any new medications, creams, or herbs, have new sun exposure, or start using a tanning bed before any subsequent treatments.

☐ I certify that the preceding medical, personal, and dermatological history statements are true and correct. I am aware that it is my responsibility to inform Pelle Spa providers of my current medical conditions. I agree to abide by the above policy statements. I understand that, as with any cosmetic procedure, individual results may vary and that NO refunds will be given. I understand that if I am dissatisfied with the results of the services rendered that I am not entitled to a refund. I understand that as a valued customer of Pelle Spa, that I may contact them to determine if there is a remedy for my dissatisfaction. If I choose not to allow Pelle Spa to remedy the issue, or if I choose to allow Pelle Spa to remedy and I am still dissatisfied, that I am not entitled to a refund. I hereby release the technician performing the procedure, Pelle Laser Spa, LLC and Annette Randlemon, CNP from all liabilities associated with any and all of the above indicated procedures.

Signature

_____ Date _____

Signature of Parent/Guardian (if patient is under 18)

_____ Date _____

Provider Name and Signature

_____ Date _____