Cosmetics

MEDICAL FORM

Welcome, and thank-you for choosing Apple Cosmetics! In order to provide you with safe and effective treatments, please fill out this questionnaire completely. All information is strictly confidential. If you have any questions, please ask and we will be happy to help you.

CLIENT INFORMATION

Name: _____ Today's Date_____ Birthdate_____

Address: _____ City: _____

Province: _____ Postal Code: _____ E-mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person to contact in case of emergency: _____

Relationship: _____ Phone Number: _____

MEDICAL HISTORY

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

If yes, for what: _____

_____

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

If yes, for what: _____

Any previous surgery/treatments? _____

Any scarring? Location? How old? _____

UV Exposure? E.g. tanning beds, sunbathing, self-tanner, outdoorsman, etc. Do you use? How often?

How recent? _____

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

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you using birth control pills? ☐ Yes ☐ No

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Do you have any of the following medical conditions? (Please check all that apply)

- ☐ any active infection
- ☐ Auto Immune disease
- ☐ Blood clotting abnormalities
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fainting tendency
- ☐ Fever blisters
- ☐ frequent cold sores
- ☐ Glaucoma
- ☐ Heart disease (e.g. Rheumatic fever, Angina, Pacemaker, etc.)
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Hormone imbalance
- ☐ Keloid scarring
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Psoriasis
- ☐ Seizure disorder
- ☐ Skin disease/Skin lesions
- ☐ Smoker
- ☐ Thyroid imbalance
- ☐ Tuberculosis
- ☐ Metal or Dental Implants

Do you have any other health problems or medical conditions? Please list: _____

_____

Do you have any allergies? If yes please list: _____

_____

MEDICATIONS

What oral medications are you presently taking? _____

_____

Have you ever used Accutane? ☐ Yes ☐ No

If yes, when did you last use it? _____

What topical medications or creams are you currently using? ☐ Retin-A ☐ Others (Please list)

_____

What herbal supplements do you use regularly? _____

Are you taking any medication that is Photosensitizing? ☐ Yes ☐ No

My signature below represents the following:

- 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 Apple Cosmetics of my current medical or health conditions and to update this history
- I understand a current medical history is essential for the caregiver to appropriate treatment procedures
- I agree to cooperate to the best of my ability and to comply with the instructions and advice relative to my follow-up care
- I agree to have Apple Cosmetics contact me via e-mail for updated information and promotions

Patient's Name_____Patients Signature_____