

Skin Care Consultation and Medical History Form

Date: ____/____/____

Name: _____ DOB: ____/____/____

Address: _____

Phone: _____ Cell/Home/Work Email: _____

Occupation: _____ Does your Job require you to work outside? Y or N

How did you hear about 18 Spa? (Please check all that apply) WebSearch _____ FB _____ Insta _____
Referral _____ By: _____ Other: _____

Future Contact: May we call/text/email you about future appointments and services? Y or N

May we email you about promotions and future changes and update? Y or N

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Have you ever had a facial treatment before? Y or N If yes, when was your last treatment? _____

Have you been under the care of a physician, dermatologist, or other medical professional within the past year? Y or N If yes, please explain: _____

Any recent surgery, including plastic surgery? Y or N If yes, when and please explain: _____

Have you ever had any of the following health conditions in the past or present? (check all that apply and provide additional information as needed below)

- | | | |
|---|--|---|
| <input type="radio"/> Cancer | <input type="radio"/> Hormone Imbalance | <input type="radio"/> Systemic Disease |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Thyroid Condition |
| <input type="radio"/> Hysterectomy | <input type="radio"/> Diabetes | <input type="radio"/> Heart Problems |
| <input type="radio"/> Arthritis | <input type="radio"/> Asthma | <input type="radio"/> Eczema/Psoriasis |
| <input type="radio"/> Seizure Disorder | <input type="radio"/> Headaches | <input type="radio"/> Hepatitis |
| <input type="radio"/> Herpes/Cold Sores | <input type="radio"/> Immune Disorders | <input type="radio"/> HIV/AIDS |
| <input type="radio"/> Lupus/Autoimmune | <input type="radio"/> Blood Clotting Disorders | <input type="radio"/> Psychological |
| <input type="radio"/> Keloid Scarring | <input type="radio"/> Skin Disease/Disorders | <input type="radio"/> Fainting |

Allergies to food? Y or N If yes, explain: _____

Allergies to medications? Y or N If yes, explain: _____

Do you take any medications regularly? _____

Are you on taking oral contraceptives? Y or N Recent changes to your contraceptive method? Y or N

Are you pregnant or trying to become pregnant? Y or N Are you lactating? Y or N

Any menopause problems? Y or N Last menstrual cycle? _____

Do you follow a restricted diet? Y or N If yes, explain: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

Do you exercise regularly? Y or N What is your stress level? High Medium Low

Do you smoke? Y or N Do you drink alcohol? Y or N

Do you use illegal drugs? Y or N Do you have trouble sleeping? Y or N Hours of sleep? _____

Do you wear contacts? Y or N Do you have metal implants or a pacemaker? Y or N

Are you claustrophobic? Y or N Do you suffer from sinus problems? Y or N

SKIN CARE

Score		0	1	2	3	4
	Natural Eye Color	Light Blue, Green	Blue, Green	Blue	Brown	Dark Brown
	Natural Hair Color	Sandy Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black
	Color of Unexposed Skin	Reddish	Very Pale	Pale with Beige Tint	Light Brown, Olive	Dark Brown
	Freckles on Sun Exposed Areas	Many	Several	Few	Incidental	None
	When in the Sun Too Long	Painful Redness, Blister, Peel	Blister followed by Peeling	Burn Sometimes, Peel	Rarely Burn	Never Burn
	How Easily do you Tan	Hardly, Not at All	Light Color Tan	Moderate Tan	Tan Easily	Dark Quickly
	Several Hours after Sun do you Tan	Never	Seldom	Sometimes	Often	Always
	Face React to Sun	Very Sensitive	Sensitive	Normal	Very Resistant	No Problem
	Last Sun/Tan Exposure	More than 3 Months	2-3 Months	1-2 Months	Less than 1 Month	Less than 2 Weeks
	Exposure of Treatment Area to Sun	Never	Hardly Ever	Sometimes	Often	Always

Total Score: _____

Fitzpatrick Skin Type _____

What is your daily skin care regimen? _____

Have you ever had an adverse reaction after using a skin care product?

- Rash
- Sun sensitivity
- Irritation
- Breakout
- Peeling
- Other: _____

Which of the following best describes your skin type?

- Very Oily Skin, Large Pores
- Oily Skin
- Combination Skin, Oily in T-Zone, Dry Cheeks
- Dry Skin
- Sensitive Skin

Have you ever had an allergic reaction to the following? If yes, explain _____

- | | | | |
|---------------------------------|----------------------------------|------------------------------------|------------------------------------|
| <input type="radio"/> Cosmetics | <input type="radio"/> Medication | <input type="radio"/> Citrus Fruit | <input type="radio"/> Aspirin |
| <input type="radio"/> Animals | <input type="radio"/> Iodine | <input type="radio"/> Pollen | <input type="radio"/> AHAs |
| <input type="radio"/> Fragrance | <input type="radio"/> Shellfish | <input type="radio"/> Latex | <input type="radio"/> Other: _____ |

Have you ever had microdermabrasion, dermaplaning, laser or chemical peels? Y or N

In the past month? Y or N

Have you had any recent piercings, tattoos, or permanent make-up? Y or N If yes, when: _____

Do you use Retin-A, Renova, Retinol/Vit A derivative, or Adapalene Hydroxyl Acid products? Y or N

If yes, explain: _____

Have you used in the past month? Y or N

Have you used in the past 3 months? Y or N

Have you used any acne medication? Y or N If yes, explain: _____

Do you have any special skin problems or concerns pertaining to your face and/or body? Y or N

Please specify: _____

Do you form thick or raised scars easily? Y or N

Do you have hyperpigmentation? Y or N

Do you have hypopigmentation? Y or N

Have you had hair removal in the past 6 weeks? Y or N If yes, explain: _____

SUN HISTORY & LIFESTYLE

How often do you work outdoors?

- | | |
|----------------------------------|------------------------------------|
| <input type="radio"/> Frequently | <input type="radio"/> Occasionally |
| <input type="radio"/> Rarely | <input type="radio"/> Very Rarely |

How often do you use sunscreen?

- | | |
|----------------------------------|------------------------------------|
| <input type="radio"/> Frequently | <input type="radio"/> Occasionally |
| <input type="radio"/> Rarely | <input type="radio"/> Very Rarely |

How often do you use tanning beds?

- | | |
|----------------------------------|------------------------------------|
| <input type="radio"/> Frequently | <input type="radio"/> Occasionally |
| <input type="radio"/> Rarely | <input type="radio"/> Very Rare |

What SPF do you use on your face? _____ How often/when? _____

What SPF do you use on your body? _____ How often/when? _____

Have you had any recent sun exposure or tanning beds that have changed the color of your skin? Y or N

Have you had any recent Botox, Dermal Filler, or Collagen injections? Y or N If yes, explain: _____

Any recent microneedling? Y or N If yes, when? _____

PREVIOUS PROCEDURES

Which of the following have you had in the past?

- | | | |
|---|---|---|
| <input type="radio"/> Botox | <input type="radio"/> Dermal Fillers | <input type="radio"/> Microdermabrasion |
| <input type="radio"/> Facials | <input type="radio"/> Chemical Peels | <input type="radio"/> Dermaplaning |
| <input type="radio"/> Waxing | <input type="radio"/> Electrolysis/Laser Hair Removal | <input type="radio"/> Tattoo Removal |
| <input type="radio"/> Microneedling | <input type="radio"/> Permanent Make-Up | <input type="radio"/> Skin Tightening |
| <input type="radio"/> Cellulite Reduction | <input type="radio"/> Skin Resurfacing | <input type="radio"/> Skin Rejuvenation |
| | | <input type="radio"/> |

_____ (initial) I willfully consent to allow 18 Spa, its owner, staff, employees, the ability, and option to select my photographs and videos for their media and marketing. Specifically, these reproductions may be shown on television, the internet, our social media, and website. Photographs and videos may include facial structures as well as body images or full body representations, with or without any partial or full nudity. My personal information will not be disclosed and all identifying information will be concealed.

_____ (initial) In adherence with Rule 800, our spa, 18 Spa, and its Medical Director, Dr. Bernardini, MD, are offering you medical grade aesthetic services. This notice is to inform you of the following, all standard and usual and customary according to Rule 800:

1. Dr. Jonathan Bernardini, MD is our Medical Director, Board Certified in Anesthesiology and extensively trained in medical grade aesthetic consultations and procedures, and
2. Dr. Bernardini delegates his licensure and authority to practice to the contractors and staff of this aesthetic spa, so he/she may provide services to you today, and
3. Any delegatee who practices outside of his/her scope of practice, does so per Dr. Bernardini's authority with training and advanced certification from third party agencies, and
4. Dr. Bernardini is available for pre-procedure advice, consultation or post-procedure advice, complication treatment, remedy, or consultation upon request.

_____ (initial) I agree that, in the uncommon event of an unexpected aesthetic result or outcome, I will make a consultation with Dr. Bernardini to review the clinical aesthetic details and attempt to find a root cause of the unexpected outcome. This review will be directly with Dr. Bernardini and will include a full review of treating staff members, dates, times, products, services, photos, consents, and payments, and any other meaningful data or information. The purpose of such consultation is twofold: first, review all pertinent data between Dr. Bernardini and I, and also to ensure that I fully understand that the unexpected outcome may or may not have been in the consent form, preventable or not preventable, and may or may not have been reasonable and a potential known complication of the aforementioned procedure.

I understand, have read, and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications an/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform my skin care professional of my current medical or health conditions and an up-to-date history. The treatments I receive here are voluntary and I release 18 Spa and its staff from liability and assume full responsibility thereof.

Client Name (printed) _____ Date _____

Client Name (signature) _____

Skin Care Professional (signature) _____