HEALTH HISTORY INFORMATION

Name: _____ Today's Date: _____
Last First MI

Street address_____

City: _____ State:_____ Zip:_____

Date of birth: _____ Age: _____ Sex: ☐ Female ☐ Male

Home Phone: _____ Cell Phone: _____

Leave messages at: ☐ Home ☐ Cell ☐ Other: _____

Email address: _____
I consent to this email address being added to the MediSpa at Reneu email newsletter, where I will get information on specials and promotions. ☐Yes ☐No

Occupation:_____

Primary Care Physician/phone number: _____

In case of Emergency, who should be notified? (name and phone)

_____

Unless otherwise indicated, we have permission to communicate changes in your health status, including surgery, to other physicians participating in your care. ☐Yes, may notify ☐ No, please do not notify.

Do you have any major medical problems, serious illness? ☐Yes ☐ No If so, please list:

_____

_____
Please list all prior surgical procedures and dates performed:

_____

_____
Please list all injectable procedures (Botox, Juvederm, Belotero, Radiesse, Kebella, etc) and dates performed:

_____

_____

MEDICAL HISTORY

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No
Do you suffer from "photosensitivity" (extreme sensitivity to sunlight)? ☐ Yes ☐ No
Do you have a history of easy/excessive Hyperpigmentation? ☐ Yes ☐ No
Do you form keloid scars? ☐ Yes ☐ No
Do you suffer from seizures? ☐ Yes ☐ No
Do you have any metal implants? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No
Have you taken Accutane, Retin A or Renova in the past 12 months? ☐ Yes ☐ No
Are you currently taking Coumadin (Warfarin) or other blood thinners? ☐ Yes ☐ No
Do you require antibiotics before procedures such as dental cleanings? ☐ Yes ☐ No
Do you smoke? ☐Yes ☐No If yes packs per day? _____
Do you drink alcohol? ☐Yes ☐No If yes quantity per week? _____

Have you ever had an adverse reaction to laser or cosmetic treatments?
If so, please list:
_____

Are you allergic to any medications? ☐Yes ☐No
If so, please list:
_____

Do you have any other allergies? ☐Yes ☐No
If so, please list:
_____

Do you take any of the following (please check all that apply and/or list additional medications):

☐ Antibiotics
☐ Anti-coagulants
☐ Anti-depressants
☐ Appetite depressants
☐ Aspirin or Ibuprofen
☐ Blood Pressure Medication
☐ OTHER _____
☐ Cortisone or steroids
☐ Hormones/contraceptives
☐ Insulin
☐ NSAIDS
☐ Sedatives
☐ Thyroid Medication

Are you taking herbal preparations or vitamins (St. John's Wort, Vitamin E, etc.)? ☐Yes ☐No

Are you or might you be pregnant? ☐Yes ☐No
Are you trying to become pregnant? ☐Yes ☐No
Are you nursing? ☐Yes ☐No

Have you ever had any problems with any of the following anesthetics? If so, please specify.

☐Block (e.g. dental): Ineffective / Heart palpitations / Systemic reaction/ Other _____
☐Local: Ineffective / Heart palpitations / Systemic reaction / Other_____
☐Topical: Ineffective / Heart palpitations / Systemic reaction / Other_____

Have you ever had or do you have any of the following (please check all that apply):

- ☐ Active Infection
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blistering Sunburns
- ☐ Circulation Problems/Blood Clots
- ☐ Neurological Disorders
- ☐ Pigmentation Disorders
- ☐ Melanoma
- ☐ Scleroderm
- ☐ Sensitive Teeth
- ☐ Skin Injury
- ☐ Unusual Moles
- ☐ Vision Deficits
- ☐ Cold Sores / Shingles
- ☐ Hormonal Imbalance
- ☐ Insomnia / Sleeping Problems
- ☐ Joint Injury
- ☐ Multiple Sclerosis
- ☐ Muscle Pain / Spasms
- ☐ Permanent Makeup / Tattoo
- ☐ Psoriasis
- ☐ Recent Surgery
- ☐ Sensitive Teeth
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Varicose Veins
- ☐ OTHER _____

- ☐ Collagen Disorder
- ☐ Easy Bruising
- ☐ Diabetes (Type) _____
- ☐ Eczema

- ☐ Endorcrine / Hormonal Issues
- ☐ Fatigue
- ☐ Headaches / Migraines
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Heart Condition
- ☐ High / Low Blood Pressure

SKIN CARE HISTORY AND CONCERNS

Please list any products that irritate your skin:

_____

_____

Have you had unprotected sun exposure or been in a tanning booth in the last 2 weeks? ☐Yes ☐No

Do you use self tanners? ☐Yes ☐No If yes, when was last application? _____

Are you planning a vacation in the sun in the next 3-6 months? ☐Yes ☐No

Have you used any of the following hair removal methods in the past 6 weeks?:

☐Shaving ☐Waxing ☐Electrolysis ☐Plucking/Tweezing ☐Stringing ☐Depilatories

Please indicate your current skin care products/regimen:

_____

_____

Therapist/Provider Reviewed (sign) _____ Date _____

EXCLUSIONARY CRITERIA FORM

☐Yes ☐No I have had unprotected sun exposure, used a tanning bed or applied a tanning cream in the area(s) to be treated within the six weeks prior to my first treatment on a regular basis (tanned skin will not be treated with laser). Protected sun exposure means wearing protective clothing or the daily use of an SPF-30 or greater sunscreen.

☐Yes ☐No I have used a mechanical form of epilation with the six weeks prior to my first treatment (this applies to laser hair removal treatments only). Mechanical epilation includes plucking, waxing, tweezing, electrolysis, threading, or sugaring.

☐Yes ☐No I have known allergies to medications, latex, foods or other substances that may be used during the course of treatment. If Yes, list allergies here:_____

☐Yes ☐No I have a history of seizures. Flashing lights may trigger a seizure.

☐Yes ☐No Medications. I am taking or St. John's Wort. I am taking a medication or herbal remedy that may make my skin sensitive to light (photosensitizing).

☐Yes ☐No I have a history of keloid and hypertrophic scar formation. Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason it is recommended to exclude from treatment clients with known tendency to form keloid or hypertrophic scars. Clients with this history are evaluated on a case bye case basis to determine if treatment can be performed.

☐Yes ☐No I have an active infection or am immunosuppressed. (Active infections and immunosuppression compromise the healing ability of the body).

☐Yes ☐No I have an open lesion in the area to be treated.

☐Yes ☐No I have a history of Herpes I or II within the area to be treated.

***Please note a "yes" to any of the above may exclude client from the light therapy (laser/BBL) treatments.

Print Patient name: _____

Signature:_____ Date: _____

Witness:_____ Date: _____

MY SPECIFIC CONCERNS AND INTERESTS

(Please check all that apply and indicate any prior treatments in space provided.)

SKIN	**SCARS**
☐ Dry or Oily Skin	☐ Body
☐ Skin discoloration	☐ Face
☐ Brown Spots	
☐ Acne	**VEINS**
☐ Rosacea	☐ Legs
☐ Fine Wrinkles	☐ Face
☐ Deep Wrinkles	☐ Other
LOWER FACE	
☐ Lip Lines	**SKIN TIGHTENING – FACE & BODY**
☐ Nasolabial Creases	☐ Under Eyes
☐ Marionette Lines	☐ Under Chin
CHIN / NECK/HANDS	☐ Abdominal
☐ Loose Skin	☐ Flanks
☐ Aging Hands	☐ Arms
HAIR GROWTH	
☐ Body Hair	**WEIGHT GAIN**
☐ Facial Hair	☐ Metabolic
	☐ Supplements
BODY CONTOURING/FAT REDUCTION	☐ 1 on 1 Visits
☐ Chin	
☐ Arms	**COSMETIC GYNOCOLOGY**
☐ Abdominal	☐ Vaginal Rejuvenation
☐ Flanks	☐ Vulvar Rejuvenation
☐ Legs	☐ G-Spot Enhancement
☐ Bra Bulge	
	PRODUCTS
SUPPLEMENTS	☐ Lashes
☐ Weight Loss	☐ Eye Lift
☐ Antioxidants	☐ Skin Tightening
☐ Metabolic Boost	☐ Acne
	☐ Wrinkles
	☐ Age Spots

Client Signature:_____Date:_____

Provider Signature:_____ Date:_____

SKIN TYPING FORM

Patients Name: _____Date:_____
(Please circle what applies to the best of your knowledge)

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray Green	Blue, Gray	Green	Brown	Brownish Black
What is the natural color of your hair	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin (non exposed areas)?	Reddish	Very pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	Never	Hardly ever	Sometimes	Often	Always
Did you expose the area to be treated to the sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago *

Below to be completed by the Reneu Health & Medispa Staff

Total score: _____

*Patient may not be eligible for treatment until at least 2 weeks after exposure.

Patients Name: _____Date: _____

Skin Type Score	Fitzpatrick Skin Type	Typical Ethnic back ground
0-7	I	Irish, English, Scottish
8-16	II	Irish, English, Scottish
17-25	III	Dark Caucasian, light Asian
25-30	IV	Hispanic, Asian, Native American, Mediterranean, Light Middle Eastern,
30-35	V	Latin, Islander, Dark Middle Eastern, Light African American,
Over 35	VI	Dark African American

Fitzpatrick Skin Type: _____ Clinical Skin Type:_____

Treatment Skin Type should be the highest skin type calculated for the patient by either Fitzpatrick or Clinical observation.

Treatment Skin Type: _____

Comments:_____

Consultant: _____Signature: _____Date: _____

Provider: _____Signature: _____Date: _____

ACKNOWLEDGEMENT OF PRACTICE POLICIES

I understand that I will receive traditional spa or cosmetic medical treatment from the Reneu Health & Medispa. Some of the various treatments the Reneu Health & Medispa provides include: massage therapy; facials; waxing; chemical peels; microdermabraison; laser hair removal; photo rejuvenation/BBL; skin resurfacing; skin tightening; UltraShape,Venus Legacy or Tickle Lipo, Botox® Cosmetic injections and filler injections. I understand that depending on the treatment I select, I will be required to sign an informed consent specific to that treatment.

_____(Please Initial).

I am fully aware that my condition is solely of a cosmetic nature and that the decision to proceed is based on my expressed desire to do so:

_____ (Please Initial).

Payment Policy

I understand that my treatments at the Reneu Health & Medispa require payment and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by the Reneu Health & Medispa. For cosmetic medical procedures, I understand that the services often require more than one session for best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There is no guarantee of refunds on treatments paid in advance. Any refunds will be determined on a case by case basis after appropriate management approval. I further understand that the services offered by the Reneu Health & Medispa are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, check or most major credit cards._____ (Please Initial).

Cancellation and Late Policy

I am aware that the Reneu Health & Medispa requires 24 hours notice of a cancellation and that it is my responsibility to provide timely notice by calling the Reneu Health & Medispa. I agree to pay a $25.00 fee if I fail to give the required 24 hours notice. If I have prepaid my treatment session or sessions, I understand that I may forfeit one of my future sessions if I do not provide the Reneu Health & Medispa with the required 24 hours notice. _____ (Please Initial).

The Reneu Health & Medispa asks that I arrive 15 minutes prior to each of my scheduled appointment time(s) so that all appointments can run both efficiently and timely. Late arrivals may result in a reduction of treatment time or appointment being rescheduled, along with a cancellation fee of $25.00 if appointment has to be rescheduled.
_____ (Please Initial).

Return Policy

All sales of skin care and makeup products are final. Unopened products may be returned with a receipt for a credit within 30 days.

_____ (Please Initial)

Disclaimer

I understand that all medical cosmetic treatments are provided exclusively by the Reneu Health & Medispa. I will not hold the Reneu Health & Medispa, its owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that the Reneu Health & Medispa cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion: _____ (Please Initial).

I understand that even with the best laser and the highest trained technicians, as high as 10-15% of patients will not have a desired response/outcome to treatments. _____ (Please Initial).

Privacy

I have received a copy of the Reneu Health & Medispa Notice of Privacy Practices. _____ (Please Initial).

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent:

Print Patient Name: _____ Patient Signature: _____Date:_____

I have explained the above statements to the client and answered all questions.

Clinical Staff Name: _____ Clinical Signature: _____Date_____