



SKIN CONSULTATION INTAKE FORM

Name _____ DOB ____/____/____ Today's date: _____
Last First Mo Day Yr

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone:() _____ Cell Phone:() _____ Work Phone:() _____

E-mail _____ *How did you hear about us? _____

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES NO

- Are you using any prescribed medications? List _____
- Are you using any herbal medications? List _____
- Do you take oral anti-coagulant (blood thinning) medication?
- Are you allergic to any cosmetic ingredients, medications or foods? List _____

- Are you pregnant or trying to become pregnant?
- Do you use oral contraceptives?
- Do you use hormone replacement therapy?
- Do you smoke? How much? _____ How long? _____ When did you quit? _____
- Do you spend a lot of time outdoors or use a tanning bed often?
- Do you have any tattoos or permanent makeup?
- Do you have any allergies to eggs, egg proteins, or human albumin?
- Do you have any neuromuscular or autoimmune diseases?
- Do you have any allergies to latex?
- Do you have a fear of needles?

Please answer the following questions:

Which skin problems concern you the most (Check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Brown spots (Hyperpigmentation) | <input type="checkbox"/> White spots (Hypopigmentation) |
| <input type="checkbox"/> Uneven skin tone | <input type="checkbox"/> Visible exposed blood vessels | <input type="checkbox"/> Hard bumps under skin |
| <input type="checkbox"/> Enlarged pores | <input type="checkbox"/> Clogged pores | <input type="checkbox"/> Blackheads /Whiteheads |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Excessive oiliness | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Upper lip lines | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Sun Spots | <input type="checkbox"/> Dry patches | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Other: _____ | | |

What is your skin type: Dry Combination Oily Normal

How much water do you consume per day? _____

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

- | | | |
|--|--|--|
| <input type="checkbox"/> Cleanser _____ | <input type="checkbox"/> Soap _____ | <input type="checkbox"/> Toner _____ |
| <input type="checkbox"/> Moisturizer _____ | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Mask _____ |
| <input type="checkbox"/> Eye cream _____ | <input type="checkbox"/> Astringent _____ | <input type="checkbox"/> Glycolic Wash/Cleanser |
| <input type="checkbox"/> Scrub _____ | <input type="checkbox"/> Sunscreen _____ | <input type="checkbox"/> Salicylic Wash/Cleanser |
| <input type="checkbox"/> Vitamin A Cream | <input type="checkbox"/> Vitamin C Creams | <input type="checkbox"/> Alpha or Beta Hydroxy Cream |

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?

Please list _____

Have you ever had any of the following wrinkle fillers or implants:

- Collagen Juvaderm Restylane Radiesse Perlane Silicone Hylaform
- Other: _____

* If so, then when was it done? _____ What area? _____

Have you had any other cosmetic surgeries/procedures? _____

When? _____ Were you pleased with the results? _____

Please check any health problems, past or present:

- | | | | | |
|--|---|---|---|---------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cystic Acne | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Collagen (Lupus, Sarcoid, Scleroderma) | <input type="checkbox"/> Vasovagal Syncope/Fainting | |
| <input type="checkbox"/> Other: _____ | | | | |

Do you have any of the following chronic skin disorders?

- | | | | |
|---|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sun Blisters | <input type="checkbox"/> Herpes Simplex/Blisters |

Have you ever undergone any of the following treatments?

- Microdermabrasion Acid Peel Cosmetic Surgery Accutane

Please Explain _____

Are you currently removing hair by any of the following methods?

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Tweezing | <input type="checkbox"/> "Nair" type products |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Laser Hair Removal | |

- If so, when was it done? _____ What area? _____
- What type of laser/equipment? _____

LMA Med Spas Notes:



LMAesthetics
Dr. Mulligan

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Laser Medical Aesthetics may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Laser Medical Aesthetics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Laser Medical Aesthetics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Laser Medical Aesthetics Privacy Officer at (175 1st place NW Suite C, Issaquah, Washington 98027).

With my consent, Laser Medical Aesthetics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Person and Confidential.

With my consent, Laser Medical Aesthetics may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Laser Medical Aesthetics restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Laser Medical Aesthetics' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Laser Medical Aesthetics may decline to provide treatment to me.

Patient's Name

Date

Signature of Patient