

Mill Creek Skin & Laser Center
Medical History & Client Questionnaire

Date: _____

Reason for Visit: _____

PERSONAL HISTORY

First Name : _____ Last Name: _____

Address: _____ City: _____ Zip Code: _____

Date of Birth: _____ Occupation: _____

Preferred Contact Phone #: (____) _____ Is this your [Home] [Cell] [Work] number?

Alternate Contact #: (____) _____ Is this your [Home] [Cell] [Work] number?

May we leave a message regarding your upcoming office visit, account information, or other pertinent Information at the above numbers? [Yes] [No]

Would you like to receive specials/promotional offers via email: [Yes] [No]
If yes, Email: _____(please print clearly)

Are you interested in hearing about our membership? [Yes] [No]

How did you hear about us? _____

SKIN TYPING / FITZPATRICK

Some treatments require us to collect race information to ensure proper settings to avoid any complications. You may check more than one.

Caucasian: ___ Hispanic: ___ Asian: ___ African American: ___

Italian: ___ Native American: ___ Other (please list): _____

Which of the following best describes your skin type when first exposed to the sun without sun protection?
(Circle one skin type)

Skin Type	Description
I	White, always burns, never tans
II	White, always burns, sometimes tans
III	White, sometimes burns, always tans
IV	White, rarely burns, always tans
V	Brown, Asian, moderately pigmentation
VI	Black skin, always tan

Are you currently under the care of a physician? If yes: Physicians Name: _____

Are you currently under the care of a Dermatologist? If yes: Dermatologist Name: _____

Do you have any of the following conditions? **Check all that apply.**

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure/Heart Condition | <input type="checkbox"/> Diabetes/Insulin |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Skin Disease/Lesions History of Skin Cancer |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Hormone Imbalance |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Blood clotting abnormalities |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Orthopedic Replacements | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Seborrhea | <input type="checkbox"/> Other |

None

If Other, please list: _____

Any active infections, medical conditions? [] Yes [] No

If yes, please list _____

Any Dermatological Conditions? [] Yes [] No

If yes, please list _____

What Medications are you presently taking?

Accutane (Isotetrinoin) (if yes, list date last used): _____

Birth Control Pills: _____

Hormones: _____

Minoxidil (Rogaine) (if yes, list date last used): _____

Retin-A (if yes, list date last used): _____

Renova: _____

Anticoagulant/blood thinner: _____

Others: _____

None

What Vitamins/Herbs are you presently taking? _____

Allergies: **None Known**

Have you ever had an allergic reaction to any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Metal _____ | <input type="checkbox"/> Photoallergenic |
| <input type="checkbox"/> Latex _____ | <input type="checkbox"/> Lidocaine _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cosmetics _____ | <input type="checkbox"/> Hydroquinone or skin bleaching agent's _____ | |
| <input type="checkbox"/> Aspirin _____ | <input type="checkbox"/> Hydrocortisone _____ | |

Acne: **Not Applicable**

Do you have a history of breakouts? [Y] [N]

If so, how frequent? [Frequent] [Occasional] [Rarely]

Do you experience cystic breakouts? [Y] [N]

Do you have any scarring as a result from your acne [Y] [N]

For our female clients

Are you pregnant or trying to become pregnant? Are you using Contraception?

Are you breastfeeding?

Previous Treatments

Have you ever had a laser treatment? [Y] [N]

If yes, how long ago, what laser treatment and what body area(s) were treated? _____

What Facility or Clinic? _____

Skin History

_____ Have you had recent tanning or sun exposure that changed the color of your skin?

_____ Have you recently used any self-tanning lotions?

_____ Do you form thick or raised scarring from cuts or burns?

_____ Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (Lightening of the skin)

_____ Threading (weaving of threads to remove hair)

_____ Other (please list): _____

Have you had any Botox, Juverderm or Restylane (or other collagen fillers) in the past 6 months [Y] [N?]

(If yes, please list): _____

PAYMENT POLICY

Full payment for services rendered must be received PRIOR to treatment. We accept Visa, Mastercard, Debit Cards, Care Credit* and cash. We do not accept checks.

***Care Credit purchases of \$250 or more.**

APPOINTMENT POLICY

Our Doctor and Aestheticians value your time and we request that you value theirs. The first two appointments not kept, cancelled, and/or rescheduled at least 48 hours prior to the scheduled appointment time will be charged \$50.00 each. The third and all subsequent appointments not kept, cancelled, and/or rescheduled at least 48 hours prior to the scheduled appointment time will be charged \$100.00 each. Missed appointment fees must be paid at the next scheduled appointment.

For appointments lasting one hour or more, a reservation fee is required at time appointment is made.

CHILD CARE POLICY

We do not offer child care. Mill Creek Skin & Laser can be a dangerous environment for unsupervised children. We do not allow your children to be unsupervised at any time. For the safety of your children, we recommend you make alternative arrangements for the care of them. We reserve the right to reschedule your appointment if you do not have proper child care. We apologize for any inconvenience this may cause you but this is for the safety and protection of your children.

Mill Creek Skin & Laser reserves the right to refuse service to anyone.

Client Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Official Use Only

Doctor / Therapist Recommendations: _____