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AESTHETICS & WELLNESS

CLIENT INFORMATION, MEDICAL HISTORY & LEGAL DISCLOSURE

In order to provide you with the most appropriate treatment, we need you to update us on any new medical history since your last appointment with us. All information is strictly confidential.

PERSONAL HISTORY

Client Name: _____

Today's Date: _____ Date of Birth: _____ Age: _____

Occupation: _____

Home Address: _____

City: _____

State/Zip Code: _____

Home Phone : _____ Mobile Phone: _____

Email: _____ Is it okay to leave a voice message? Y / N

Emergency Contact

Name: _____ Phone: _____

How did you hear of us or how were you referred to us?

- ☐ Instagram
- ☐ Facebook
- ☐ Pinterest
- ☐ Advertisement
- ☐ Swerve Salon and Spa: _____ (name of person, if applicable)
- ☐ Friend: _____ (name of friend)
- ☐ Other: _____

Do you regularly sun bathe or use tanning salons? Yes / No

Do you smoke tobacco? Yes / No

Do you drink alcohol? Yes / No

MEDICAL HISTORY

Are you currently under the care of a physician or dermatologist? Yes / No
Reason: _____
Do you have any of the following medical conditions? (Please check all that apply)

- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Herpes/cold sores
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Lupus
- ☐ Keloid scarring
- ☐ Blood clotting abnormalities
- ☐ Any active infection
- ☐ Seizure disorder
- ☐ Arthritis
- ☐ Hormone imbalance
- ☐ Thyroid imbalance
- ☐ Skin disease/Skin lesions (eczema, psoriasis, skin cancer, etc.)
- ☐ Other: _____

Allergies
Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)

- ☐ Food: _____
- ☐ Animal Protein, (i.e. egg)
- ☐ Aspirin
- ☐ Lidocaine
- ☐ Hydrocortisone
- ☐ Hydroquinone / skin bleaching agents
- ☐ Others: _____

Medications
What oral or topical prescription or nonprescription medications are you presently taking?

_____

_____

Are you currently taking any of the following?

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Blood thinners

If So, Please list type and last dose taken: _____

What topical medications or creams are you currently using?

- ☐ Retin A, or retinoid products
- ☐ Others (Please list): _____

What herbal supplements do you use regularly? _____

FEMALE HISTORY

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

Are you breastfeeding? Yes / No

PHOTO CONSENT

Medical Chart Photo/Video Consent (not optional)
I hereby authorize Aria Aesthetics and Wellness to take pre-procedural, and post-procedural photographs, slides, and/or videotapes. I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by the nurse practitioners at Aria Aesthetics and Wellness and I understand that they shall be made a part of my medical record.

Patient Signature or guardian:_____ Date:_____

Consent for Release of Media (optional)
I hereby authorize Aria Aesthetics and Wellness nurse practitioners to use pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on public or commercial television, electronic digital networks, scientific medical publications, lay publications, or during lectures to medical or lay groups for the purposes of informing the medical community or the general public about aesthetic or medical treatment procedures available at Aria Aesthetics and Wellness. Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. This permission may be rescinded by me at any time to prohibit future use by direct written communication with Aria Aesthetics and Wellness.

Patient Signature or guardian:_____ Date:_____

SIGNATURE

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.
I hereby authorize that any legal claims made towards Aria Aesthetics and Wellness, PLLC, will only involve the practitioners performing the procedure and/or the owners of Aria Aesthetics and Wellness, PLLC. I release the facility (Swerve Salon and Spa), the staff of the facility, and the medical director from any liability

Signature: _____

Print name: _____

Date & time: _____

TO BE DOCUMENTED PER NURSE PRACTITIONER

Reviewed by: _____ Date/time: _____