METROPOLITAN MED SPA

8170 Silverbrook Road
Lorton, VA
www.metropolitanmedspa.com
703-738-9969

Client Information and Medical History

In order to provide you with the most appropriate skin care treatment or laser hair removal, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Date: _____

Client Name _____ Date of Birth _____/_____/_____ Age _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____ **Email Address** _____

Occupation _____ **Emergency Contact Name and Phone** _____

How were you referred to us? _____

Which of the following best describes the concerns that you have with your skin that you would like us to address? (Please check all that apply)

_____ Acne/ Acne Scars	_____ Brown/Age Spots	_____ Sun Damage/ Spots
_____ Fine Lines/Wrinkles	_____ Larger Pore Size	_____ Psoriasis
_____ Ingrown Hairs/ Razor Bumps	_____ Skin Toning	_____ Oily Skin
_____ Warts	_____ Eczema	_____ Rosacea/ Redness
_____ Blackheads	_____ Facial Redness	_____ Melasma
_____ Stretch Marks	_____ Cellulite	_____ Broken Capillaries
_____ Spider Veins/Leg Veins	_____ Facial Veins	_____ Hair Removal
_____ Collagen Reproduction	_____ Skin Rejuvenation	_____ Dark Eye Circles
_____ Loose Skin	_____ Fat in certain areas	_____ Puffiness around Eyes

MEDICAL HISTORY

Are you currently under the care of a physician? _____ Yes _____ No

Are you currently under the care of a dermatologist? _____ Yes _____ No

Are you on any mood altering or anti-depression medication? _____

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Do you currently or have a history of the following medical conditions? (Please check all that apply)

_____ Livido Reticularis
_____ Cancer
_____ Herpes
_____ Hirsutism
_____ Skin Disease/Lesions
_____ Lupus
_____ Thyroid Imbalance
_____ Vitiligo
_____ Phlebitis
_____ Polysistic Ovarian Disease
_____ Cirrhosis of the Liver
_____ Asthma
_____ Auto-immune Disease
_____ Diabetes
_____ Arthritis
_____ HIV/AIDS
_____ Seizure Disorder
_____ Hepatitis
_____ Blood Clotting Abnormalities
_____ Bleeding Abnormalities
_____ Blood Thinning
_____ Renal Insufficiency
_____ Heart Disease
_____ Pulmonary Disease
_____ Erythema ab igne
_____ High Blood Pressure
_____ Frequent Cold Sores
_____ Keloid Scarring
_____ Epilepsy
_____ Hormone Imbalance
_____ Psoriasis
_____ Leg Ulcer
_____ Obesity
_____ Stroke
_____ Hypertension
_____ Immune Deficiency

Do you have any other health problems, medical conditions or medications? Please List: _____

_____

COSMETIC HISTORY

Are you currently taking the following medications? (Please check all that apply)

_____ Accutane, how long?_____
_____ Hormones
_____ Antibiotics
_____ Antivirals
_____ Coumadin
_____ St. John's Worts

Have you previously had or are you currently under treatment with the following?

_____ Retin A
_____ Microdermabrasion
_____ Tanning/ Tanning Creams
_____ Glycolic Acid
_____ Chemical Peel
_____ Tattoo/Permanent Makeup
_____ TCA Peels
_____ Laser Treatments
_____ Skin Lighteners

Have you ever had laser hair removal? _____ Yes _____ No

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

_____ Shaving
_____ Plucking
_____ Depilatories
_____ Waxing
_____ Tweezing
_____ Sugaring
_____ Electrolysis
_____ Stringing
_____ Threading

Are you currently pregnant or trying to become pregnant? _____ Yes _____ No

Are you breastfeeding? _____ Yes _____ No
Are you using contraception? _____ Yes _____ No
Do you follow a regular exercise program? _____ Yes _____ No
Do you smoke? _____ Yes _____ No
Do you drink alcohol daily? _____ Yes _____ No

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Please List all surgeries, including cosmetic that you have had.

_____

_____

_____

ALLERGIES

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced).

_____ Food _____ Latex _____ Cosmetics __ Aspirin _____ Lidocaine __ Hydrocortisone
_____ Hydroquinone or skin bleaching agents _____ others: _____
Reaction: _____

What products do you currently use as your skin care regimen? _____
_____

How would you rate your skin (please check all that apply)?

` Sensitive	` High Tolerance	` Moderate to Oily	` Oily in most areas
` Average Tolerance	` Oily	` Dry	` Dry in most areas

Which of the following best describes your skin type? (Please circle one type number)

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Black skin

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the laser technician of my current medical or health conditions and to update this history. A current medical history is essential for the laser technician to execute appropriate treatment procedures.

Signature _____ **Date** _____

FOR OFFICE USE ONLY:

_____
_____
_____
_____
_____
_____
_____

Metropolitan Med Spa
Informed Consent for Hair Removal

Customer's name:_____Date:_____

I authorize Metropolitan MedSpa to perform Laser/IPL treatments using Candela's GentleMax

Treatment sites: mono-brow, lip, chin, neck, face, arms, fingers, chest, areola, linea, underarms, back, buttocks, bikini, labia, scrotum, thighs, lower legs, feet, and toes.
Combinations: _.

Previous hair removal methods_____(shaving, tweezing, waxing, depilatories, electrolysis, laser)

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasion there are clients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

Alternative methods are waxing, shaving, electrolysis, and chemical epilation.

Thefollowingproblemsmayoccurwiththehairremovalsystem.

1. **There is a risk of scarring.**

2. **Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation** (browning) and **Hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change is a rare risk.** Avoiding sun exposure before and after the treatment reduces the risk of color change.

3. **Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary with the help your health care provider at your own expense.

4. **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.

5. **Allergic Reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

6. **Avoid sun exposure**: for 1-2 months following treatment. When exposed to sunlight, use of sunscreen with SPF of 25 or above is required at all times.

7. I understand that exposure of my eyes to light could harm my vision. My eyes will be covered with laser/IPL-specific safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during treatment.

8. Compliance with the after care guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation. By signing below I acknowledgethat I have received Laser Hair Removal Client Instructions.

9. If oxygen is used during my treatment, my provider will ensure that it is used safely. Oxygen supports combustion and may cause flash burns in the treatment area. Anesthesia is usually not necessary. My provider or I may elect to use a form of topical anesthesia to reduce any discomfort during the procedure. A cryogen sprays in cooling device may be used during the procedure to decrease discomfort and protect the skin. I accept that all anesthesia options and risks have been discussed with me in advance.

10. Metropolitan MedSpa, LLC, does not have access to physician, medical doctor (M.D.).Also, Metropolitan MedSpa, LLC, is completely a separate entity from Gentle Dental Care.

11. You have consulted your healthcare provider before these treatments.

12. If a client cancels/no shows appointment within 48 hours he or she will forfeit that treatment.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT:

____I have provided my past and current medical history and medications.
_____I consent to the taking of photographs during the course of my laser therapy for healthcare records.
_____I consent to using my photographs for medical education and/or marketing purposes. Mynamewillnotbeusedtoidentifythesephotographs.
_____I am not pregnant (female clients).

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Metropolitan Med Spa, LLC, its officers, employees, technicians or agents from all liabilities associated with the above indicated procedure.

Client/Guardian Signature_____Date_

Laser Technician Signature_____Date_____

Metropolitan Med Spa
Scale Evaluation

Please circle the answer that applies for each question:

Genetic Disposition:

	0	1	2	3	4
My eye color is	Light blue, gray, green	Blue, gray, or green	Blue	Dark Brown	Brownish-Black
Natural color of my hair	Sandy, red	Blond	Chestnut / Dark Blond	Dark Brown	Black
Color of unexposed skin	Reddish	Very pale	Pale with beige tint	Light Brown	Dark Brown
How many freckles on unexposed skin	Many	Several	Few	Incidental	None

Total score for Genetic Disposition: _____

Reaction to Sun Exposure:

	0	1	2	3	4
How many skin reacts when I stay in the sun too long	Painful redness, blistering, peeling	Blistering and peeling	Burns/Peels sometimes	Rarely burns	Never burns
How brown do I get in the sun	Hardly or not at all	Light tan	Medium tan	Tan very easily	Dark tan very easily
Do I turn brown after several hours of sun exposure?	Never	Seldom	Sometimes	Often	Always
How does my face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total score for Reaction to Sun Exposure:_____

Tanning Habits:

	0	1	2	3	4
When did I last expose my body to sun, tanning booth/cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
How often is the treatment area exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for training Habits: _____

Total score of all three sections: _____

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
26-30	IV
Over 30	V-VI

Patient: _____Date: _____

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Dear Client

Please be advised should you need to reschedule an appointment do so 48 hours in advance. You will forfeit a treatment session for NO SHOWS when rescheduling with less than 48 hour notice. All purchased packages are NON-REFUNDABLE.
Packages have expiration date of 12 months from date of purchase.

Metropolitan Med Spa communicates with clients using text messages to confirm appointments and upcoming promotions. By signing below, you are agreeing to receiving these messages.

Thank you for your understanding!

Management

Client Name Client Signature