NTOC MED SPA Medical History Form

Patient Name:_____

Date:_____

Email Address: _____

Phone Number:(_____)_____

GENERAL

Are you currently under the care of a physician?

YES☐NO☐ If yes, please note:_____

Are you currently under the care of a dermatologist?

YES☐NO ☐ If yes, please note:_____

Do you have a history of a persistent skin rash produced by prolonged or repeated exposure to sunlight radiation? YES☐NO☐

Do you smoke? YES☐NO☐

Do you wear contact lenses? YES☐NO☐

Have you undergone chemotherapy or radiotherapy in the past 5 years? YES☐NO☐

Do you have any of the following medical conditions?

Cancer☐	**Seizure Disorder☐**
Diabetes☐	**Hepatitis☐**
High Blood Pressure☐	**Hormonal Imbalance☐**
Herpes☐	**Thyroid Imbalance☐**
Arthritis☐	**Blood clotting abnormalities☐**
Cold Sores☐	**Any Active infection☐**

HIV/ AIDS ☐ **Psoriasis/Vitiligo/Lupus** ☐

Keloid Scarring ☐ **G6PD Deficiency** ☐

Skin disease/ skin lesions ☐

Melasma ☐

Others (please list)**:**_____

Do you have any health problems or medical conditions? Please note**:**

_____

_____

Have you ever had an allergic reaction to any of the following? (describe the reactions you've experienced) **FOOD** ☐ **LATEX** ☐**ASPIRIN**☐**LIDOCAINE** ☐**HYDROCORTISONE**☐ **HYDROQUINONE**☐**SKIN BLEACHING AGENTS**☐ **ALOE VERA**☐**OTHERS:**

_____

_____

MEDICATIONS

What oral medications are you presently taking?

BIRTH CONTROL PILLS ☐**HORMONES** ☐**ANTICOAGULANTS** ☐**ASPIRIN** ☐

ANALGESICS ☐**ANTI-INFLAMMATORY** ☐**ANTI-EPILEPTICS** ☐**ANTIBIOTICS** ☐

INSULIN ☐**HIGH BLOOD PRESSURE** ☐

OTHERS(please note)**:**_____

Are you on any mood altering or anti-depression medications: YES ☐**NO** ☐

Have you ever used Accutane? YES ☐**NO** ☐

If yes, when did you last use it?_____

What topical medications or creams are you currently using? (including skincare)

_____

_____

Are you currently using topical Retin A/Retinol, Glycolic Acids, Lactic Acids or any other form of chemical exfoliants? (if yes, please indicate)**:**

_____

What herbal supplements/ vitamins are you using regularly?:_____

_____

HISTORY

Have you ever had light based treatments? YES☐NO☐

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

SHAVING☐WAXING☐ELECTROLYSIS☐TWEEZING☐THREADING☐
OTHER:

_____

Have you had any recent tanning/sun exposure that changed the colour of your skin?

YES☐NO☐

Is your usual work environment outdoors? YES☐NO☐

Have you recently used any self tanning lotions/treatments within the past 4 weeks?

YES☐NO☐

Do you form thick or raised scars from cuts/burns? YES☐NO☐

Do you have any hyperpigmentation(darkening of the skin) YES☐NO☐

Hypopigmentation(lightening of the skin) YES☐NO☐

Do you get marks on your skin after physical trauma? YES☐NO☐

FEMALE PATIENTS

Are you pregnant, or trying to become pregnant? YES☐NO☐

Are you breastfeeding? YES☐NO☐Are you using contraception? YES☐NO☐

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 technician, medical esthetician, doctor or nurse of my current medical or health conditions and to update this history form should any changes occur during my treatment regimen. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature:_____ Date:_____

Consent Form

For Hair Reduction, Skin Rejuvenation, IPL Photofacial, Pigmented lesions, Vascular Lesions, Acne, Tempsure RF, Flexsure, Dry eye Treatment, Skin needling, Chemical Peels.

Name:_____ Date:_____

I authorize you to perform any of the procedures listed above. I am aware that these treatments are intended to result in; hair reduction, skin rejuvenation, or improvement of pigmented lesions, vascular lesions, skin tightening, acne, scarring, reduction of fat cells, improvement of dry eye syndrome, and ocular rosacea. I understand and accept that it is necessary to conduct more then one treatment to achieve results. I also accept that it may be necessary to use other manors of treatments, including proper skin care products to prevent/treat/reduce sun damage and more.
If you are being treated with IPL/Hair reduction it is common to be red/swollen for a period of time. It is common to encounter darkening of skin lesions which can potentially become raised and crusty for a period of time. **Do not scratch, or pick at these lesions as scarring may result.** We are unable to treat patients who are taking **accutane** and **photosensitizing medications.** Failure to provide full disclosure of medications can hinder results and is of the responsibility of the patient to provide accurate information to the provider. Client is responsible to keep the provider up to date with any changes in medical history for the duration of treatment period. The following may occur with treatment:

1. Scaring: the pulsed light can create a bruising and a moderate burn/ blister to the skin and will be red (erythema) there is a risk of scarring in burned skin cases.
2. Hyperpigmentation and hypopigmentation have been noted to occur after treatments, especially with a darker complexion. This usually resolves within weeks, but can take as long as 3-6 months in some cases. Permanent colour change is a rare risk. **Avoiding sun exposure before and after treatment is crucial to reduce the risk of colour change and burns.**
3. Infection: although infection following treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to individuals with a past history of herpes simplex virus infections in the area. Should any type of skin infection occur, additional treatment including antibiotics will be necessary. **If you have a history of herpes simplex virus in the treated area we recommend preventative therapy.**

4. Bleeding: Pinpoint bleeding is rare but can occur following pigmented and vascular lesion treatment procedures. Should bleeding occur, additional treatment may be necessary.
5. Skin tissue pathology: Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated by your provider. Check with your doctor for a clearance for the treatment.
6. 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. Allergic reactions may require additional treatment.
7. **Wear sunscreen of SPF 40 or higher before and after treatment to protect your skin. We highly recommend patients use sunscreen at all times.**
8. I understand that exposure to light could harm my vision. I will keep the eye protection that is provided on at all times during the treatment session.
9. Compliance with the aftercare guidelines is **crucial** for healing, prevention or scarring, hyperpigmentation and hypopigmentation. 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 at the clinic. Please be understanding if any conveniences occur.

ACKNOWLEDGEMENTS

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and understand the risks. I hereby release NTOC and NTOC MedSpa from all liabilities associated with the above indicated procedures.

Patient / Guardian Signature:_____

Date:_____