

CLIENT INFORMATION & INFORMED CONSENT

Today's Date (MM/DD/YY)____/____/____ As of today's date, are you over the age of 18? Yes____ No____

First Name_____ Last Name_____

Emergency Contact: Name_____ Phone #_____ Relationship_____

Have you seen a health care provider in the last 2 years? If yes, what for?_____

Are you currently under his/her care? Yes____ No____ What for?_____

Please indicate if you have/had the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Recent surgery or acute injury | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Arthritis/Joint Disorder |
| <input type="checkbox"/> Cardiac/Circulatory Problems | <input type="checkbox"/> Breast Cancer/Radiation | <input type="checkbox"/> Actinic keratosis | <input type="checkbox"/> Numbness/Stabbing Pains |
| <input type="checkbox"/> Skin Disease/Skin Lesions | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Frequent cold sores | <input type="checkbox"/> Blood Clotting |
| <input type="checkbox"/> Using Retin-A® or Accutane® | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> History of Seizures | <input type="checkbox"/> Allergic to Vegetable Dyes |
| <input type="checkbox"/> Presence of raised moles/warts | <input type="checkbox"/> Allergies | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Immuno-suppression |
| <input type="checkbox"/> Hyper/Hypo-pigmentation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Keloid Scars | <input type="checkbox"/> Do you bruise easily? |
| <input type="checkbox"/> Cancer/Malignant Tumors | <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Dermal Filler | <input type="checkbox"/> Blood Thinning Medications (Aspirin) |
| <input type="checkbox"/> Hormonal Imbalance | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Varicose/Spider Veins |
| <input type="checkbox"/> Pregnant (or think you might be) or nursing | <input type="checkbox"/> Active infection | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Taking Birth control | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Topical medications or creams | <input type="checkbox"/> Oral Topical Antibiotics | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Do you wear contact lenses? |
| <input type="checkbox"/> Skin Peels or Laser Treatments/Surgery in the last six weeks | | | |
| <input type="checkbox"/> Recent sun exposure, tanning bed exposure, or self tanner. If so, How often?____ When tanning, do you burn easily?____ | | | |
| <input type="checkbox"/> Allergic reaction to: <input type="checkbox"/> Food <input type="checkbox"/> Latex <input type="checkbox"/> Aspirin <input type="checkbox"/> Lidocaine <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Hydroquinone or skin bleaching agents <input type="checkbox"/> Other_____ | | | |

Please list current medications, supplements & cosmetics_____

Which, if any, cosmetics/skin care products are you allergic to?_____

Do you have any medical condition that we should be aware of?_____

What do you expect from this visit? (Example: scar reduction, improve acne, relaxation, etc)_____

For Permanent Makeup: Moles or freckles at site of tattoo Have you ever had a cold sore? Yes No If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores. By signing this consent, I have read above information regarding ZOVIRAX and understand its use is mandatory if I desire lip line or full lip color procedures.

PLEASE READ CAREFULLY: With my signature below, I certify that I'm at least 18 years old and that I have fully disclosed my medical history and have answered all the specific health questions. I have had the opportunity to ask questions regarding the treatment/procedure and my questions have been answered to my satisfaction. I have been satisfactorily informed of possible risks (if any) and benefits (if any) of the proposed treatment(s), authorize and direct ESI to perform the procedure and understand that results cannot be guaranteed. When applicable, aftercare guidelines are crucial for healing and prevention of scarring, hypo- and hyper-pigmentation and other conditions, and I understand that copies of "Post Treatment Suggestion" forms are available to me at no charge. I will also notify European Skincare & Med Spa of any changes in my health as they occur during my treatment program, as well as the addition of new medication, birth control pills, herbs, supplements, vitamins not listed above. As a client/patient of European Skincare & Med Spa, I understand and agree to abide by the spa's no-show cancellation policy.

Client/Patient Signature

Parent/Guardian Signature (if under 18 years)