51850 Dequindre Rd., Suite 3
Shelby Township, MI 48316
Phone: 855-855-1SPA (1772)
Fax: 586-739-2300
Evolutionmedspa.com

CLIENT INFORMATION & MEDICAL HISTORY (page 1 of 4)

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name ____ Date of Birth ____________________

Occupation __________________________________ Employer _________________________________

Home Address________________________________ City___________________ Zip Code __________

Home Phone (_______)________________________ Cell Phone (_______)_________________________

Email ____

How did you hear about us? ____

Emergency Contact Name_____________________ Phone ____________________Relationship __________

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

What's your ethnicity? ____
Do you regularly sun bathe or use tanning salons? _________________ How often? ______________________
Do you smoke? ______________________________________ ______How often? ______________________
Do you exercise? ____ How often? ______________________

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, why:
____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No
If yes, why: ____

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Do you have a history of erytherma abigne, which is persistent skin rash produced by prolonged or repeat exposure to moderately intense heat or infrared irritation? □ Yes □ No

Do you have any of the following medical conditions? (Please check all that apply)
□ Cancer □ Diabetes □ High blood pressure □ Herpes □ Arthritis
□ Frequent cold sores □ HIV/AIDS □ Keloid scarring □ Skin disease/Skin lesions
□ Seizure disorder □ Hepatitis □ Hormone imbalance □ Thyroid imbalance
□ Blood clotting abnormalities □ Any active infection

Do you have any other health problems or medical conditions? Please list: ________________________________
____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) □ Food □ Animal Protein □ Aspirin □ Lidocaine □ Hydrocortisone
□ Hydroquinone or skin bleaching agents □ Others: ____
____

MEDICATIONS

What oral prescription medications are you presently taking? □ Birth control pills □ Hormones
□ Others (It is required that you list all of them): ____
____

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

Have you ever used Accutane? □ Yes □ No If yes, when did you last us it? _______________________________

What topical medications or creams are you currently using? □ Retin-A® □ Others (Please list): ______________
____

What herbal supplements do you use regularly? ____

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

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Have you used any of the following hair removal methods in the past six weeks? □ Shaving □ Waxing □ Electrolysis □ Tweezing □ Stringing □ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? □ Yes □ No

Have you recently used any self-tanning lotions or treatments? □ Yes □ No

Do you form thick or raised scars from cuts or burns? □ Yes □ No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? □ Yes □ No If yes, please describe: ____
____

For our female clients:

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, 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.

Signature ____ Date _____________________

Primary Phone Number: ____
I grant Evolution Medical Spa permission to call me on my primary phone number I listed above to speak with me or leave me messages regarding my upcoming appointments. I understand these messages will NOT reveal any confidential information other than my appointment date and time. I understand the purpose of the call is a friendly reminder of my next appointment. **If your appointment requires further instructions or special preparation, we will simply request a return call to discuss such matters with you directly**.

Please initial yes________ or no__________

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Cancellation Policy: Evolution Medical Spa appreciates you as a patient and our entire staff wishes to maintain a positive and professional relationship with you. We also understand it is a mutual agreement that both, your time and our staff's time are valuable. To best serve you and all of our patients, our staff makes every effort to provide the highest quality care a medical setting could offer and in a timely manner, when you have a scheduled appointment. As a courtesy, we ask you for a 24 hour cancellation notice to avoid a NO SHOW fee of $25.00 per missed visit. This fee must be paid before your next scheduled visit. We understand personal situations and emergencies happen on occasion and an appointment must be rescheduled. Please call our office in a timely manner to avoid this fee. **I acknowledge that I received a copy of the Spa Policies.**

____ ____

Patient Signature   Today's Date

Print Patient Name ____

Media Consent

I hereby consent that any and all photographs and videos taken or ordered by Evolution Medical Spa, of any part of my body, whether originals or reproductions, may be utilized for such purposes as he/she may desire in connection with his/her research, writing, professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with his/her research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade. This consent is not retractable, either by oral or written means and stands for all time until the end of time. PLEASE INITIAL ONLY ONE OPTION.

_________I have read and understand the above mentioned and sign below giving consent to the foregoing and any photographs taken for future procedures.

Patient's Signature   **Date**

_____I DO NOT consent

Patient's Signature   **Date**