Allure Cosmetic Laser Center Client Medical History

____
Patient Name **Date**

____
Address **City, State, Zip Code**

____
Home Phone **Cell Phone** **Work Phone**

____
Social Security # (Insurance Patients Only) **Date of Birth**

____
Email Address **Employer** **Occupation**

How were you referred to our office?

Groupon	_____	**Yodle**	_____	**Derma MD**	_____
American Health & Beauty	_____	**Spa Finder**	_____	**Vein Directory**	_____
S Magazine	_____	**Allure Website**	_____	**LaserHairRemoval.com**	_____
Living Social	_____	**Jack FM**	_____	**Vegas.com**	_____
Internet Search	_____	**Sunny 106.5**	_____	**Party 93.1**	_____

Patient _____ **Who?** ____

CCSD Employee _____ **Who?** ____

Physician _____ **Who?** ____

Other _____ ____

I would be interested in more education for the following procedures:

Laser Hair Removal	_____	**Chiropractic Care**	_____
Microdermabrasion	_____	**Hormone Balancing**	_____
Chemical Peels	_____	**Nutritional Counseling**	_____
SRA Foto-Facials	_____	**Nutritional Supplements**	_____
Levulan Treatment	_____	**Injectables & Fillers**	_____
BLU-U Treatment	_____	**Permanent Make-up**	_____
ST Refirme	_____	**Wrinkle Reduction**	_____
Spider/Varicose Vein Therapy	_____	**Exilis Body Contouring**	_____
Lipo-dissolve	_____	**Smart Lipo / Vaser Lipo**	_____
Laser Skin Resurfacing	_____	**Fractional Laser Resurfacing**	_____

This critical information is used to develop a customized skin treatment for you. Please provide the following information:

HEALTH

Within the last year, have you been under a dermatologist's care? seYڤ oNڤ
Dermatologist's Name: ____

Have you had any of these health problems in the past or present?
dioryhtڤ ymotceretsyhڤ yrujni lanipsڤ ecnalabmi enomrohڤ smelborp traehڤ yspelipeڤ setebaidڤ recnacڤ condition ڤvaricose veins ڤsystemic disease ڤliver ڤkidney ڤasthma ڤlung ڤconstipation ڤhypertension
sititapehڤ evitisop VIHڤ sesobmorhtڤ erusserp doolbڤ
If yes, please explain: ____

Do you follow a strict diet? seYڤ oNڤ

Do you take any vitamins, prescribed drugs, blood thinners, diet pills, minerals, over the counter meds and or supplements? seYڤ oNڤ
If yes, please list: ____
Do they make you photosensitive? seYڤ oNڤ

Do you use any acne medications or antibiotics (oral or topical)? seYڤ oNڤ
For example: Renova, Accutane, Zovirax. Please list: ______________________________

Are you allergic to any cosmetic ingredients/medications? Please list **ALL** medicines or cosmetic ingredients that you are allergic to or had reactions of any kind: ______________________________

Have you ever had a reaction to any of the following? ڤcosmetics ڤmedicine ڤiodine ڤpollen ڤhydroxy acids ofaesڤ sdica cilycilasڤ sneercsnusڤ ecnargarfڤ slaminaڤod/food ڤother: ______________________
____

How much water do you drink daily?____

How many alcoholic beverages do you consume weekly? ______________________________

Do you smoke? seYڤ oNڤ

Do you exercise regularly? seYڤ oNڤ

Do you have regular sleep patterns? seYڤ oNڤ

Do you wear contact lenses? seYڤ oNڤ

Do you have metal implants or a pacemaker? seYڤ oNڤ

Have you had or planning to have any surgery? seYڤ oNڤ
If yes, please specify: ____

Do you burn easily in moderate sunlight? seYڤ oNڤ

Do you blush easily when nervous? seYڤ oNڤ

Do you have a tendency for redness? seYڤ oNڤ

Do you suffer from sinus problems? seYڤ oNڤ

Do you sweat easily? seYڤ oNڤ

Do you drink caffeinated beverages (coffee, tea, soft drinks)? seYڤ oNڤ
How many daily? (combined)____

Do you ever experience a burning, itching sensation on your skin? seYف oNف
Where? ____

How is your pain tolerance? woLف hgiHف muideMف

What type of massage pressure do you prefer? tfoSف mriFف muideMف

FEMALES

Are you taking oral contraceptives? seYف oNف

Have you changed brands of contraceptives within 6 months? seYف oNف

Are you pregnant / lactating or trying to become pregnant? seYف oNف

Is your menstrual cycle regular? seYف oNف

Do you have unwanted hair on your face or breasts? (hormones) seYف oNف

MALES

What is your current shaving system? vahs yrdف evahs tewف cirtceleفe

Do you experience ingrowns or irritation from shaving? seYف oNف

SKIN

What conditions/problem areas would you like improved? فsun damage/age spots فexcessive oiliness yrdف senil nworf/selknirwف senil pil reppuف serop deggolcف selkcerfف selpmip/encaفpatches فscarring فfacial hair/ingrowns فbroken capillaries فbrown spots/uneven tone فblackheads/whiteheads فhard bumps under skin/milia فwarts فrosacea فother: ____

Do you experience any of the following? فpsoriasis فdermatitis فfever blisters/cold sores فrosacea فeczema sdiolekف ssenthgitف niks fo ssenikalfف etilullecف placs yrdف noitardyhedف strawف selomف

Any facial scarring? seYف oNف
Location: ______________________________________ How old is scar? __________________________

With what temperature of water do you cleanse? tohف mrawف dlocف

Have you seen any skin changes lately? seYف oNف
Please explain: ____

Do you sunbathe or use tanning beds? seYف oNف

Do you ever experience an oily shine during the day on your face? seYف oNف yllanoisaccOف

Do you ever experience skin breakouts? seYف oNف yllanoisaccOف

Is your T-zone oily during the day? seYف oNف llanoisaccOفy

Do you experience skin rashes? seYف oNف

Which form of hair removal do you use? فlaser فdepilatories فtweezing فelectrolysis فwaxing

Have you ever had chemical peels, laser, microdermabrasion
or any resurfacing treatments? seYف oNف
How long ago? ____

Are you currently using any products that contain the following? dica cilycilasف dica citcalف dica cilocylgف
_____________ :rehtoف enoniuqordyhف loniterف dica yxordyhف sburcs gnitailofxeف___________

SKIN TYPE WORKSHEET

Patient Name: ___________________________ Date: __________________

Score		0	1	2	3	4
	What is the color of you eyes?	Light Blue, Light Gray, or Light Green	Blue, Grey, or Green	Dark Blue, Dark Grey, Dark Green, Light Brown	Dark Brown	Brown-Black,
	What is the natural color of your hair?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish, Very Pale	Pale with a beige tint	Light Brown	Dark Brown	Black
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, Severe Burns, Blistering, Peeling	Burns, followed by peeling	Rarely burns	No burns, just darker skin tone.	Never had burns, very little reaction at all to sun exposure
	To what degree do you tan?	Hardly or not at all	Light tan color	Reasonably tan	Tan very easily	Turn dark quickly
	Do you tan several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

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

SOME DRUGS THAT CAUSE PHOTOSENSITIVITY

ANTICANCER DRUGS

Dacarbazine
Fluorouracil
Flutamide
Methotrexate
Vinblastine

ANTIHISTAMINES

Cyproheptadine
Diphenhydramine

ANTIDEPRESSANTS

Amitriptyline
Amoxapine
Clomipramine
Desipramine
Doxepin
Imipramine
Maprotiline
Nortriptyline
Phenelzine
Protriptyline
Trazodone
Trimipramine

ANTIHYPERTENSIVES

Catopril
Diltiazem
Methyldopa
Minoxidil
Nifedipine

ANTIPARASITIC

Chloroquine
Quinine
Thiabendazole

ANTIMICROBIALS

Ciprafloxacin
Clofazimine
Dapsone
Demeclocycline
Doxycycline
Enoxacine
Flucytosine
Griseafulvin
Lomefloxacin
Minocycline
Nalidixic Acid
Narfloxacin
Oflaxacin
Oxytetracycline
Pyrazinamide
Sulfonaides
Tetracycline

St. John's Wort

ANTIPSYCHOTICS

Chlorpromazine
Fluphenazine
Haloperidol
Perphenazine
Prochlorperazine
Thioridazine
Thiothixane
Trifluoperazine
Thioflupromazine

DIURETICS

Acetazolaminde
Amiloride
Bendroflumethiazide
Chlorothiazide
Furosemide
Hydrochlorothiazide
Hydroflumethiazide
Methclothiazide

PLEASE CALL 24 HOURS AHEAD OF YOUR APPOINTMENT TO CANCEL OR RESCHEDULE. IF AN APPOINTMENT IS MISSED WITHOUT NOTICE, THERE WILL BE A $25 CHARGE.

____

Signature **Date**

REFUND POLICY

It is the policy of Allure Cosmetic Laser Center NO REFUNDS are given.

Credit for any unused treatments may be applied to any other laser, facial, or non-invasive treatments. Deposits for SmartLipo, Liposuction, Vein Treatments and Aesthetic packages are Non-refundable.

THANK YOU

____

Signature **Date**

ALLURE COSMETIC LASER CENTER, INC
MUTUAL BINDING ARBITRATION AGREEMENT

Patient's name____

This mutual binding arbitration agreement constitutes an integral part of a contract for medical treatment by and between Allure Cosmetic Laser Center,Inc., Leo J. Capobianco, D.O., LTD, (Hereafter referred as Allure) and any of its employees or contract staff, and ____ who agrees to be bound as described hereunder:

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary of unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration by the American Arbitration Association office in Las Vegas, Nevada, as provided in Nevada Law, and not by lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Any arbitration proceedings must take place in the State of Nevada. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
2. Procedures to enhance one's appearance and or reduced weight are considered desirable and elective. There may be conflicting evidence to support the medical necessity for such procedures. Patient understands that they have chosen to undergo this procedure even though a conflict in medical necessity exists.
3. Such arbitration shall be *in* accordance with the current arbitration rules of the American Arbitration Association, even though the American Arbitration Association will not be overseeing the proceedings, yet always within accordance of Nevada Regulatory Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical services rendered, whether impatient or outpatient, against Unicorn Health Services or any of their respective employees or contract staff.
4. As all services that Allure and their employees and contract staff perform are elective and not lifesaving, the execution of this Mutual Binding Arbitration Agreement shall be a precondition of the furnishing of medical services by Allure. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative prior to undergoing any treatment or diagnostic evaluation. Allure may assume that if the patient proceeds with the treatment/evaluation that he/she is willing to abide by this **binding** arbitration agreement.
5. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT OT A JURY OR COURT TRIAL THE PREVAILING PARTY IS ENTITLED TO RECOVER FEE.

Date: ____________________________ Time: _______________________ AM/PM

Signature: ____

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