Blush
MEDICAL AESTHETICS

Skincare History

First Name _____ Last Name _____

Address _____

City _____Province_____ Postal Code _____

Date of Birth (MM/DD/YYYY) _____ Phone Number _____

Email _____

Emergency Contact

First Name _____ Last Name _____

Phone _____

Are you pregnant:

yes

no

If yes, how far along:

Do you have any of the following health conditions:

AIDS/HIV

Heart Problems

Lupus

Cancer

Hepatitis

Recent Surgeries

Diabetes

High/Low Blood Pressure

Strokes

If yes, please list the names of any prescription medication(s):

Are you using or have ever used any medications for acne?

Yes

No

If yes, how long has it been since you last used acne medication?

Do you suffer from Cold Sores?

Yes

No

If yes, do you take medication?

Yes

No

Do you smoke?

Yes

No

Do you tan?

Yes

No

Have you had facials before?

Yes

No

Have you had electrolysis, laser hair removal, or waxing in the last week?

Yes

No

What skin care products are you currently using?

Have you ever had an allergic reaction to any of the following?

Cosmetics

Sunscreen

Essential Oils

Shellfish

Medication

Iodine

Nuts

Latex

Food

Pollen

Alpha Hydroxy Acids

Aspirin

Animals

Skin Products

Fragrance

Other

If yes to any of the above, please explain:

Have you had any of the following?

Cosmetic Surgery

Dermatitis

Chemical Peels

Botox Injections

Keloid Scarring

Skin Cancer

Laser Resurfacing

Other

Other. Please explain

If yes to any of the above, please state when your last treatment was:

What areas of concern do you have regarding your skin?

Breakouts/Acne

Broken Capillaries

Sun Damage

Dehydrated Skin

Blackheads/Whiteheads

Sun/Brown Spots

Wrinkles/Fine Lines

Excessive Oil/Shine

Enlarged Pores

Dull/Dry Skin

Rosacea

Uneven Skin Tone

Flaky Skin

Other

Other. Please explain

Is there any other information I should know before beginning your treatment?

It is your responsibility to inform Blush Medical Aesthetics of any pre-existing and all health conditions. It is also your responsibility to inform your medical aesthetician of any discomfort during any session.

I, _____ , understand and accept any risks of which I have been advised associated with the agreed upon skin treatment. I release Blush Medical Aesthetics from all liability arising from any injury and/or damage from failure to inform Blush Medical Aesthetics of any pre-existing conditions, limitations, specific sensitivities, and/or any discomfort during the treatment. I agree to keep Blush updated as to any changes in my medical profile.

I, _____, hereby acknowledge and understand that I am receiving aesthetic treatment(s) described as waxing at “Blush Medical Aesthetics”. I give my voluntary and informed consent to receive the treatment(s) as listed. I understand that there may be physical contact involved in these treatments and I am not aware of any medical reasons that would preclude me from requesting or receiving treatment(s) of this nature.

I hereby agree to defend, indemnify, and save harmless “Blush Medical Aesthetics” and or it’s principles, employees, or agents from any claims which might arise in relation to any allergic reaction and or any other potential liability which might arise from or in the context of the treatment(s) received at “Blush Medical Aesthetics”. I accept any such liability as a voluntary assumption of risk and acknowledge that this is a condition precedent to receiving the treatment(s) as listed.

Before and after treatment advice/protocols have been discussed with me and that adherence to such advice / protocols is necessary for optimal treatment results and to avoid undesirable effects after treatment(s).

The treatment(s) as well as potential benefits and risks associated have been explained to me and meet my satisfaction.

I am satisfied that all my questions have been answered.

I freely consent to the treatment(s) as listed above.

Client Name: _____

Client Signature: _____

Date:(MM/DD/YYYY) _____

Parent or Guardian(18 under): _____

Date:(MM/DD/YYYY) _____