

Avante Laser & MediSpa

Microdermabrasion Client History

Name _____ Date _____

Address _____ City/State _____ Zip _____

Home Phone() _____ Work Phone() _____ Occupation _____

Marital Status _____ Date of Birth _____ Email Address _____

Referred By _____ (i.e. Person, Yellow Pages, Newspaper, Physician, or other)

May we call to confirm your appointment? Yes No Tel. # _____

Which conditions would you like to improve? (Please circle)

- | | |
|-----------------------|--|
| Hyperpigmentation | Sun damage |
| Acne Scarring | Age spots |
| Fine lines & wrinkles | Acne (how long? No. month/years) _____ |
| Surgical/facial scars | Enlarged pores |
| Stretch marks | Other _____ |

Your skin sensitivity: (please circle) Mild Moderate Severe

Are you pregnant or planning to become pregnant? _____

Are you currently under a physician's care? _____ Reason _____

Have you visited a dermatologist, plastic surgeon, or other skin care therapist? _____

Reason _____

Do you smoke? _____ If not, were you ever a smoker _____ How many years? _____

Do you have any of the following? (Please circle Y for Yes and N for No)

Acne	N	Y	Gold Therapy	N	Y	IUD	N	Y	Obesity	N	Y
Anaphylaxis	N	Y	HIV	N	Y	Implants	N	Y	Ovarian Disorder	N	Y
Canker/Cold Sores	N	Y	Hearing Aid	N	Y	Keloid Scars	N	Y	Pacemaker	N	Y
Carcinoma	N	Y	Heart Condition	N	Y	Metal Pins	N	Y	Pigmentation	N	Y
Contact Lenses	N	Y	Hemophilia	N	Y	Migraines	N	Y	Telangiectasia	N	Y
Dermatitis/Eczema	N	Y	Hepatitis	N	Y	Mitral Valve	N	Y	Thyroid Disorder	N	Y
Diabetes	N	Y	High Blood Pressure	N	Y	Prolapse	N	Y	Tuberculosis	N	Y
Genital Herpes	N	Y	Histamine Reactions	N	Y	Moles	N	Y	Vitiligo	N	Y

What allergies do you have? _____

Please list any medications (including skin medications) that you are currently taking and any that you have taken in the past 12 months.

Have you ever had any of the following treatments? (Circle Y for Yes and N for No)

Chemical peel	Y	N	Glycolic Peel	Y	N
Cosmetic surgery	Y	N	Laser Peel	Y	N
Botox	Y	N	Other Similar treatments	_____	

(Please turn over to complete form)

What products are you presently using? Cleanser _____ Moisturizer _____

Do you use or have you ever used any of the following products? (Y or N)

Retin A _____ AHA _____ Hydroquinone _____ Other _____

Do you use sunscreen daily? _____

Comments: _____

I _____, do fully understand all the questions above and have answered them all correctly and honestly. Furthermore, I know that it is my responsibility to alert the clinician about any recent surgeries or skin resurfacing procedures. Without the above disclosure I understand that the attending technician cannot optimize the effectiveness of Diamond Dermabrasion™ treatments, which are designed to provide clients with superior results. By signing below I consent to the Diamond Dermabrasion™ procedure.

Client Signature

Date

Technician Signature

Date

Technician Documentation: *(for technician only)*
