ZAFIROMED

Client Information: Aesthetic

Name: _____ Date: _____

Address: _____

Home Tel: _____ Cell: _____ Email: _____

Date of Birth: _____

Person to contact in case of emergency: _____ Phone: _____

Relationship: _____

How were you referred to us?: _____

Previous Cosmetic treatments/procedures and dates:

_____

_____

_____

Complications: __ Yes __ No Date: _____ What type of complication?

_____

_____

_____

Reason for visit

__ Initial Evaluation
__ Derma Fillers
__ Platelet Rich Plasma Administration
__ Medical Facial Peeling
__ Mesotherapy
__ Weight Control
__ Botulinum Toxin A
__ Liquid Facelift
__ Skin Care Products
__ Other:

_____

_____

Mark on the diagram to the right the facial areas you wish to discuss.

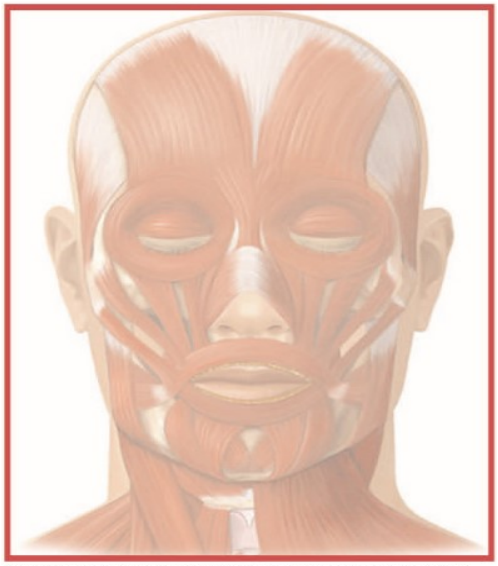
Tell us what you would like to address:

_____

_____

_____

_____



History of Anaphylactic Shock: __ Yes __ No Date: _____
History of Allergies: __ Yes __ No Date: _____

Medications

Asprin	__ Yes __ No	Steroids	__ Yes __ No
Anti-Inflammatories	__ Yes __ No	Non-Steroidals	__ Yes __ No
Anticoagulants	__ Yes __ No	(i.e. Advil, Aleve, Celebrex)	

Please list any prescription medications you use:

_____

_____

Do you take any of the following Supplements?

Ginko Biloba	__ Yes __ No	Garlic	__ Yes __ No
Vitamin A	__ Yes __ No	Flax Oil	__ Yes __ No
Vitamin E	__ Yes __ No		

Other: _____

_____

Do you have any history of the following medical conditions?

1. Multiple Severe Allergies	__ Yes __ No
2. Herpes around the Lips	__ Yes __ No
3. Immunosuppressive Therapy	__ Yes __ No
4. Autoimmune Disease	__ Yes __ No
5. Other Medical History	__ Yes __ No
6. Diabetes	__ Yes __ No
7. Cancer	__ Yes __ No
8. HIV infection	__ Yes __ No
9. Viral Hepatitis	__ Yes __ No
10. Heart Problems	__ Yes __ No
11. Amyotrophic lateral Sclerosis / Myasthenia Gravis /Muscle Weakness	__ Yes __ No
12. Keloids/ Hyperpigmentation	__ Yes __ No
13. High Blood Pressure	__ Yes __ No
14. Herpes Simplex or Cold Sores around mouth	__ Yes __ No

15. Bleeding Disorder __ Yes __ No
16. Do you have an immune disorder that would impair your healing process __ Yes __ No
17. Have you been on Accutane in the past 9 months __ Yes __ No
18. Have you had or Laser resurfacing in the past year? __ Yes __ No
19. Are you using, or have you ever used Retin-A? Last application? __ Yes __ No
20. Are you pregnant If pregnant? __ Yes __ No
21. Do you suffer from Seizures? __ Yes __ No
22. Do you have any psychological issues? __ Yes __ No
23. Have you undergone any surgical aesthetic procedures? __ Yes __ No
24. Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? __ Yes __ No
25. Local anesthetic allergies? __ Yes __ No

Comments:

_____

_____

List any Medical Conditions you have:

_____

_____

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

I Creamy complexion always burns easily, never tans
II Light complexion always burns, tans slightly
III Light/Matte complexion burns moderately, tans gradually
IV Matte complexion seldom burns, always tans well
V Brown complexion rarely burns, deep tan
VI Black complexion never burns, deeply pigmented

Is there any additional Information we should know ?

_____

_____

I have answered the above questions to the best of my knowledge.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform ZAFIRO MED of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and professional from liability and assume full responsibility thereof.

Client Signature	Printed Name	Date

Witness Signature	Printed Name	Date