Panhandle

AESTHETICS MED SPA

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ City: _____ Zip: _____

Cell (or Home) Phone: _____ State: _____

DOB: _____/_____ Marital Status: _____ Email: _____

Race: _____ Occupation: _____

Emergency Contact: _____ Contact #: _____

Primary Care Physician: _____ Pharmacy: _____

REASON FOR VISIT TODAY:

_____

Allergies: _____

Medications/Supplements: _____

_____

_____

_____

Past Surgeries:_____

_____

Smoking History: ___ Yes ___ No If so, amount per week_____

Alcohol History: ___ Yes ___ No If so, amount per week _____

Caffeine History: ___ Yes ___ No If so, amount per day _____

Sexually Active: ___ Yes ___ No If not, would you like to be? ___ Yes ___ No

# of Children: _____ Are you done having children? ___ Yes ___ No

Medical History

( ) High Blood Pressure

( ) Thyroid Problems (low or high)

( ) High Cholesterol

( ) Heart Problems

( ) Stroke

( ) Heart Attack

( ) Diabetes

( ) Irregular Heart Rate

( ) Bleeding Disorder

( ) Pacemaker/Other Metal in Body

( ) Arthritis

( ) Liver Disease

( ) Anxiety/Depression

( ) Fibromyalgia

( ) Lupus/Other Autoimmune

( ) H/o Blood Clots

( ) Liver Disease

( ) Hepatitis/HIV

( ) Herpes/Fever Blisters

( ) other

( ) Cancer (IF yes, then what kind) _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Male Patients ONLY

( ) High PSA

( ) Enlarged Prostate

( ) Trouble Passing Urine (weak or interrupted stream)

( ) H/o Steroid Use

( ) H/o Testosterone Use

( ) H/o Vasectomy

Female Patients ONLY

( ) Last Menstrual Cycle _____

( ) Last Mammogram _____

( ) Location of Mammogram _____

( ) Last GYN Exam _____

( ) Hysterectomy/oophorectomy

( ) PCOS

( ) Use of Birth Control

( ) Menopause___Yes ___NO

( ) Last Bone Density _____

( ) Family H/o Breast/Uterine Cancer (If so, who) _____

Skin/Skin Care History

( ) H/o Acne

( ) Accutane

( ) Retin A

( ) Rashes

( ) H/o Laser Treatments (If so what type) _____

( ) Warts

( ) Psoriasis

( ) Eczema

( ) H/o Skin Cancer

Current Skin Care Regimen: _____

Interest in Other Services

( ) Skin Care/Chemical Peels

( ) Lasers

( ) Weight Loss

( ) Hormone Replacement

( ) Coolsculpting/CoolTone

( ) Peptides/IV Fluids

( ) Facials/Microneedling

( ) Botox/Fillers/PRP

( ) Cosmetic Surgery

( ) Sexual Health

Signature: _____ Date: _____

Panhandle

AESTHETICS MED SPA

MEDICAL SPA RELEASE OF LIABILITY AND WAIVER

NAME: _____

CELL: _____ HOME: _____

HOME ADDRESS: _____ ZIP: _____

EMAIL: _____ DOB: ___/___/___

EMERGENCY CONTACT: _____ PHONE: _____

By signing this Medical SPA Release of Liability and Wavier, I am confirming that I recognize that there may be inherent risks associated with using certain equipment, utilizing the Medical Spa facilities, participating in programs and/or receiving Spa treatments.

I acknowledge and agree that I am responsible for my own health; that the Medical Spa associates and/or technicians are not health care practitioners and cannot be expected to diagnose and/or treat individual health problems.

I understand that I am responsible for discussing any questions that I may have concerning my health conditions (if any) throughout any program or treatment at the Medical Spa and, should health-related symptoms occur, I will cease my participation and inform Medical Spa personnel of the symptoms.

Consequently, in light of the foregoing, I hereby release the Medical Spa (and its parent corporation(s) and employees and waive any and all claims, liabilities, or damage for personal injuries that I may experience directly or indirectly from receiving Medical Spa related treatments, utilizing the Medical Spa facilities and/or participating in the programs or activities offered by the Medical Spa. Medical facility is overseen by Dr. Elise May.

_____ _____

GUEST SIGNATURE: DATE:

Any Medical Spa guest under 18 years of age must have a parent or legal guardian sign the below acknowledgment pertaining to the release of liability and waiver.

NAME OF MINOR

_____ _____

PARENT/GUARDIAN SIGNATURE DATE:

Panhandle

AESTHETICS MED SPA

PHOTO CONSENT

I **CONSENT** to the use of my photographs and/ or videos for the below stated purposes:

YES/ NO PANHANDLE PLASTIC SURGERY WEBSITE

YES/ NO PATIENT PHOTO ALBUMS HERE IN THE OFFICE OF PANHANDLE PLASTIC SURGERY

YES/ NO TEACHING LECTURES FOR OTHER MEDICAL PROFESSIONALS/ LAY GROUPS

YES/ NO MEDIA (COMMERCIAL/ ADVERTISEMENTS/ ELECTRONC DIGITAL NETWORKS)

YES/ NO PATIENT EDUCATION

I understand I will not be entitled to monetary payment or any other consideration as a result of any use of these photographs/ documents. I also understand that before signing this consent it is my right to ask any questions of Dr Elise May or her staff.

PATIENTS NAME: _____

PATIENT/ GUARANTOR SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **DATE:** _____