Wisdom & Youth, LLC

Aesthetic Medicine

Health History Information

Name: _____ Today's Date: _____
Last First MI

Street Address:_____

City: _____ State: _____ Zip:_____

Email Address: _____
I consent to this email address to be added to the Wisdom & Youth Aesthetic Medicine newsletter:
( ) Yes **( ) No**

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Home Phone: _____ Cell Phone: _____

I consent to be reminded of my appointments by text message: **( ) Yes ( ) No**

Occupation: _____

Primary Care Clinician & Phone number: _____

Emergency Contact Name: _____ Relationship: _____

Phone number of Emergency Contact: _____

Do you have any medical illnesses? ( ) Yes ( ) No
If yes, please list: _____
_____

Please list all current medications:

_____
_____
_____
_____
_____
_____

Please List any surgeries:

_____
_____
_____
_____
_____
_____

Wisdom & Youth, LLC

Aesthetic Medicine

Do you have any allergies: ( ) Yes ( ) No
If Yes, Please list:

_____

_____

Have you ever had any prior injectables such as, Botox, Juvederm, Restylane, Dysport etc.? _____

Did you experience any side effects: _____ if yes, what? _____

Do you have a pacemaker or defibrillator? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ( )Yes ( ) No
Do you suffer from photosensitivity _ ( )Yes ( ) No
Do you have a history of easy or excessive hyperpigmentation _ _ _ _ _ _ _ _ ( )Yes ( ) No
Do you from keloid scars? _ ( )Yes ( ) No
Do you suffer from seizures? _( )Yes ( ) No
Do you have any metal implants? _( )Yes ( ) No
Do you her contact lenses? _( )Yes ( ) No
Do you take Accutane or Retin-A in the past 12 months?_ _ _ _ _ _ _ _ _ _ _ _ _( )Yes ( ) No
Are you currently taking any blood thinners such as Coumadin (Warferin)? _ _ ( )Yes ( ) No

Please circle if you are taking any of the following medications:

Anabiotic's
Anticoagulants
Antidepressants
Appetite depressants
Aspirin
Blood pressure medication
Cortizone or steroids
Hormones/contraceptive
Insulin
NSAIDS (Ibuprofen/Aleve/Motrin)
Thyroid medications
Other:_____

Do you smoke: ( ) Yes ( ) No If yes, how many packs per day?_____
Do you drink alcohol: ( ) Yes ( ) No If yes, how many drinks per week?_____

Are you taking any herbal or vitamins such as a Vit E, Vit A, St. John's Wort? ( )Yes ( ) No
Are you or might you be pregnant? _ ( ) Yes ( ) No
Are you trying to become pregnant? _ ( ) Yes ( ) No
Are you nursing? _ ( ) Yes ( ) No

Wisdom & Youth, LLC

Aesthetic Medicine

Have you ever had any problems with any of the following aesthetics?

( ) **Blocks**: (eg dental) Ineffective/heart palpitations/systemic reaction/other _____
( ) **Local:** Ineffective/heart palpitations/systemic reaction/other _____
( ) **Topical:** Ineffective/heart palpitations/systemic reaction/other _____

Have you ever had or do you have any of the following (please check all that apply):

Active infection
Arthritis
Asthma
Bleeding disorders
Blistering sunburn's
Circulation problems/blood clots
Cold sores or shingles
Collagen disorder
Diabetes
Easy bruising
Eczema endocrine/hormonal issues
Eye problems
Fatigue
Fibromyalgia
Headaches/migraines
Heart condition
Hepatitis
High/low blood pressure
HIV/AIDS
Hormonal Imbalance
Insomnia/sleeping problems
Joint injury
Multiple sclerosis
Muscle pain/spasms
Neurological disorders
Permanent make up/tattoo
Pigmentation disorders
Psoriasis
Melanoma
Scaleraderma
Sensitive teeth
Skin cancer
Skin injury
Stroke
Unusual moles
Varicose veins
Visual disturbances / deficiencies
Other _____

Please list any products that irritate your skin: _____

Wisdom & Youth, LLC
Aesthetic Medicine

Areas of Interest and Concern
(Please check all that apply and indicate any prior treatments in space provided)

Concerns / Areas of Interest:	List any prior treatments & approximate date: (Accutane / Botox / Peels / IPL / Lasers / Surgery / etc.)
( ) Dry or oily skin	
( ) Skin discoloration	
( ) Brown Spots	
( ) Acne	
( ) Rosacea	
( ) Fine wrinkles	
( ) Deep wrinkles	
( ) Lip lines	
( ) Thin lips	
( ) Nasolabial creases	
( ) Marionette lines	
( ) Aging hands	
( ) Loose skin	
( ) Varicose veins	
( ) Facial / body hair	
( ) Scars	
( ) Other	

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Wisdom & Youth, LLC
Aesthetic Medicine

Acknowledgement of Practice Policies

I understand that I will receive traditional cosmetic medical treatment from Wisdom and Youth Aesthetic Medicine. Some of the various treatments provided include cosmetic Botox Injections, Dysport injections, and various filler injections. I understand that depending on the treatment I select, I'll be required to sign and inform consent specific to that treatment. _____**Please initial**

I am fully aware that my condition is solely cosmetic in nature and the the decision to proceed is based on my expressed desire to do so. _____**Please initial**

Payment Policy
I understand that my treatments at Wisdom and Youth Aesthetic Medicine require payment and the prices and fee structure for the treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by the Aesthetics staff. For cosmetic medical procedures, I understand that the services often require more than one session for the best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There is no guarantee of refunds on treatments paid in advance. Any refunds will be determined on a case by case basis after appropriate management approval. I further understand that the services offered by the Aesthetic practice are elective in nature and are not covered by health insurance. I agree to pay for the treatment in full, according to the payment plan as discussed. We except payment in the form of cash, check and most major credit cards. _____**Please initial**

Cancellation, Late and Children in facility Policy
Wisdom and Youth asks that I arrive 15 minutes prior to each of my scheduled appointment times so that all appointments can run both efficiently and timely. Late arrivals may result in a reduction of treatment time or the appointment being rescheduled along with the cancellation fee of $25 if the appointment has been rescheduled. _____**Please initial**

Children are **not** allowed in the facility or treatment rooms, and bringing them all forfeit my appointment. This is for the safety of the children and courtesy to other guests. _____**Please initial**

Return policy
All sales of skin care products are final. And open products may be returned with a receipt for a credit within 10 days. _____**Please initial**

Disclaimer
I understand that all medical cosmetic treatments are provided exclusively by the Wisdom and Youth Medical Aesthetics. I will not hold Wisdom and Youth, it's owner or it's employees responsible for the results I experience. I realize that results may vary. I further understand that Wisdom and Youth cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion: _____**Please initial**

Privacy:
I have received a copy of the Wisdom and Youth Aesthetic Medicine Notice of Privacy Practices. _____**Please initial**

I have read and fully understand all the terms of this Acknowledgment of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent:

Patient Name: _____ **Patient Signature:** _____**Date:** _____

I have explained the above statements to the client and answered all questions.

Practitioner Name: _____ **Practitioner Signature:** _____**Date:** _____