valleyskinandmedspa@gmail.com | Phone: 612-419-8338

Patient Demographic Sheet

Patient Name: _____**Today's Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____

Date of Birth: _____

Email Address: _____

How did you hear about us?

_____

Responsible Party Name (if under 18 years of age):_____

Relationship to patient: ☐ Parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Person to contact in case of emergency: _____

Relationship: _____ **Phone:** _____

I have read and understand the office HIPPA policy and understand that I can request copy of the HIPPA policy.

All professional services rendered are charged to the patient. It is customary to pay for service when rendered unless other arrangements have been made prior to the appointment.

I agree to be contacted by email. Y_ N_

I agree to have my photo taken and may be used for promotional use. Y_ N_

Patient Signature: _____**Date:**_____

7493 W. 147th Street, Suite 105, Apple Valley, MN 55124

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MEDICAL HISTORY FOR AESTHETIC PROCEDURES

Patient Name: _____DOB: _____

Reason for consultation

☐ Acne
☐ Brown spots or sun damage
☐ Enlarged blood vessels
☐ Fine lines or wrinkles
☐ Flushing of the skin
☐ Skin laxity
☐ Skin texture or scars
☐ Unwanted hair

Questions about skin

1. How long have you been concerned about this area(s)? _____
2. At what age did you notice this concern(s)? _____
3. Are your present skin concern(s) getting more pronounced? _____Yes _____ No
4. Have you ever been treated for this concern(s)? _____Yes _____ No

   If yes, when? _____

   What method? _____
5. Are you currently taking medications for your skin's concern(s)? _____Yes _____ No

   If yes, what is it? _____
6. What topical skin medications or procedures are you currently using?

   ☐ Retin-A ☐ Hydroquinone or bleaching agent ☐ Other _____
7. Have you ever had laser / IPL hair removal? _____Yes _____ No
8. Have you ever used the following hair removal methods in the past 6 weeks?

   ☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ stringing ☐ depilatories
9. Have you ever had skin resurfacing or rejuvenation or chemical peels? _____yes _____no
10. Have you ever had treatment for pigmented lesions? _____Yes _____ No
11. Do you form thick or raised scars (keloids) from cuts or burns? _____Yes _____ No
12. Do you experience hyperpigmentation (redness) from burns, cuts or insect bites? ____Yes ____ No
13. Have you had cold sores or fever blisters? _____Yes _____ No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

- Always burns, never tans ☐
- Always burns, sometimes tans ☐
- Sometimes burns, always tans ☐
- Rarely burns, always tans ☐
- Brown, moderately pigmented skin ☐
- Black skin ☐

Please continue on back side ➡

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MEDICAL HISTORY FOR AESTHETIC PROCEDURES

Sun exposure:

1. When were you last exposed to the sun or tanning booth? _____
2. Do you use self tanners? _____Yes _____ No
3. Are you planning a vacation in the sun? _____Yes _____ No

Personal history:

1. Do you smoke? _____Yes _____ No If yes _____ packs per day
2. What is your daily consumption of alcohol? _____
3. Do you wear contact lenses? _____Yes _____ No

Medical history:

1. Are you currently under the care of a physician? _____Yes _____ No
   If yes, for what:_____
2. Do you have any of the following?

☐ Arthritis	☐ Hepatitis	☐ MRSA
☐ Any active infection	☐ Herpes simplex	☐ Sensitive teeth
☐ Bleeding disorders	☐ High blood pressure	☐ Skin cancer or moles
☐ Bruising	☐ Hormone imbalance	☐ Skin injury
☐ Dark spots of pregnancy	☐ HIV/Aids	☐ Vision deficits
☐ Diabetes	☐ Keloid Scarring	☐ Neuromuscular Junction Disorder
☐ Epilepsy or seizures	☐ Motor Neuropathy	(**Such as:** Myasthenia gravis, ALS, MS)
☐ Heart disease		
☐ Other _____		

3. Do you have allergies to any of the following? (check all that apply) ☐ medications ☐ latex
   ☐ food ☐ plants ☐ anesthesia ☐ other_____
4. Do you take any of the following?

☐ Accutane	☐ Appetite suppressants	☐ Insulin
☐ Antibiotics	☐ Aspirin or Ibuprofen	☐ Sedatives
☐ Anti-coagulants	☐ Cortisone or steroids	☐ Thyroid medication
☐ Antidepressants	☐ Hormone/contraceptives	☐ Other_____

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) _____Yes _____ No
6. Are you pregnant or trying to become pregnant? (**Female patients ONLY**) _____Yes _____ No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Patient Signature: _____Date:_____

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HYDRAFACIAL TREATMENT PLAN

Pre-Treatment Instructions:

1. Discontinue use of Isotretinoin for 1 year (Sotret, Claravis, Amnesteem, and Accutane)
2. Discontinue use of topical prescription medications for 48hrs (Retin-A, Tazorac, Dierin, EpiDuo, Ziana, etc); discontinue use of OTC acne medication (Benzoyl Peroxide, Salicylic) for 72 hours.
3. Refrain from any type of exfoliating treatment(s) (glycolic, enzymes) to the area of treatment for 48hrs.
4. Refrain from waxing and use of depilatories for 48hrs.
5. Refrain from exfoliation treatments including laser procedures, chemical peels, microdermabrasion for at least 7 days.
6. If you're prone to cold sores, Hydrafacial may cause a break out; ask your doctor for a prophylactic treatment such as Valtrex. Please use medication 2 days before, during and 2 days after.
7. Avoid sun tanning or tanning creams/sprays for at least 72hrs.
8. Cosmetic injectables (Juvéderm, Restylane, Perlane, Voluma, etc) wait at least 2 weeks after injection. Shaving is not recommended prior to Gentlemen's Hydrafacial Treatment. If you choose to shave, please shave at least 3-4 hours prior to your treatment
9. The day of your appointment a full consultation will be provided. If you have any special health considerations: allergies, pregnancy, auto-immune disease, etc, be sure to notify us when you make your appointment.

Post Treatment Instructions:

1. Avoid sunbathing for at least 48hrs to prevent UV rays from damaging your skin which slows down the benefits of the Hydrafacial. Patients who absolutely cannot avoid sun exposure should use a broad-spectrum sunscreen with an SPF of 30 or higher to maintain your improved skin.
2. Injections can be resumed the same day as long as it follows your Hydrafacial Treatment.
3. Waxing and depilatories can be resumed in 48hrs.
4. Wait at least 7 days before having a chemical peel, Laser procedure and microdermabrasion.
5. Avoid heat (hot showers, sauna, and intensive cardio) for 24hrs.
6. If you do not need make-up for the evening of treatment, wait until the next morning.
7. Topical prescription medications can be resumed in 48hrs.
8. OTC acne medications may be resumed in 48hrs; wait 3-5 days before resuming topical prescription medications.
9. If you can, avoid re-applying make-up and washing your face until the following morning.
10. Optimal results will be achieved by following your Skincare Specialists recommended homecare routine.
11. The above is a guideline and not exclusive. Please contact us with any questions or concerns.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

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Patient Name_____ Patient Signature:_____

Date:_____

Fitzpatrick's Skin Type Chart

Skin Score		0	1	2	3	4
	What is your eye color?	Light Blue or Grey	Blue or Green	Hazel or Light Brown	Dark Brown	Brownish Black
	What is your natural hair color?	Red, Sandy Red	Blonde	Dark Blonde, Chestnut, Brown	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, redness, blistering and peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely Burn	Never burn
	To what degree do you turn brown?	Hardly or not at all	Light tan	Reasonable Tan	Tan very easily	Turn dark brown quickly
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never has problems in the sun
	When did you last expose yourself to the sun, tanning beds or self-tanning creams?	More than 3 months ago	2-3 Months	1-2 Months	Less than 1 month ago	Less than 2 weeks ago
	How often is the area that you want to have treated exposed to the sun?	Never	Hardly Ever	Sometimes	Often	Always
TOTAL:	**Score:** 0-7 8-16 17-25 26-30 Over 30		**Skin Type:** I II III IV V-VI			

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