

PATIENT PROFILE

Full Name: _____ Today's Date _____

Brilliant Distinctions # _____ Aspire # _____

Date of Birth: _____

Pharmacy name and Phone # : _____

Email: _____

Address: _____

City: _____ State _____ Zip Code: _____

Cell Phone: (____) _____ Cell Phone Carrier _____

May we leave voicemails or text this number? Y/N

Emergency Contact: _____ Phone: (____) _____

How did you hear about us?: _____

Race (circle one): African American/American Indian/ Alaskan Native/ Native Pacific Islander/ Asian/ White

Other: _____

Ethnicity (circle one): Hispanic or Latino/ Non-Hispanic/ Latino Unknown

MEDICAL HISTORY

Do you, or have you ever had any of the following conditions? Circle all that apply.

Autoimmune Disorder, AIDS/ HIV, Anemia, Asthma, Arthritis, Bleeding Disorder, Blood Transfusion, Blood Disease, Cancer (Chemo or Radiation), Claustrophobia, Dizziness, Epilepsy/ Seizures, Eczema, Heart Disease, Hepatitis, Diabetes, Herpes Simplex, Hormone Replacement Therapy, High Blood Pressure, Accutane, Kidney Disease, Liver Disease, Lupus, Melanoma, Mental Disorders, Neuromuscular Disorder, Photosensitive Conditions, Pigment Disorder, Psoriasis, Respiratory Issues, Skin Disease, Skin Cancer, Sinus Issues, Stomach Problems, Stroke, Tattoos, Vitiligo.

Cosmetic Injectables- if yes, date _____

Depilatory Creams- if yes, date _____

Infection (Active) Keloid/ Hypertrophic Scars

Waxing/ Tweezing- most recent date _____

List all medications you are currently taking (oral or topical medications including aspirin): _____

ALLERGIES

Medication Allergies: _____

Cosmetic Allergies: _____

Latex Allergy: _____

Food Allergies/ Other: _____

HAVE YOU USED OR ARE CURRENTLY USING THE FOLLOWING

Retin-A, Renova, Retinoic Acid Products Y/N Accutane/ Isotretinoin Y/N Sotret, Claravis, Amnesteem, Absorica, Epuris, Isotroin Y/N

Prescription Acne Medications Y/N Birth Control Pills Y/N Steroids Y/N Chemotherapy Y/N Radiation Y/N
Pacemaker/ Internal Defibrillator Y/N

PREVIOUS PROCEDURES: IF YES, DATE/AREA

Chemical Peels Y/N Superficial Metal or Other Implants Y/N Injectables/ Fillers Y/N Tattoo/ Permanent Makeup Y/N Waxing/ Hair Removal Y/N Facial Surgery Y/N Laser Surgery Y/N Microdermabrasion Y/N
Lesion/ Mole Removal Y/N General Surgery Y/N

ARE YOU CURRENTLY

Pregnant

Trying to become Pregnant Breastfeeding

Taking Blood- Thinners/ Taking Aspirin /Tanning/ Using Self-Tanners

ARE YOU CURRENTLY USING/ HAVE USED IN THE LAST 3 MONTHS

St. John's Wart , Amniodarone ,Tetracycline, Antibiotics, Anti-Coagulants,

Cold Medications, Oral/ Topical Retinoids, Oral/Topical Steroids

HAVE YOU EVER HAD

Cold sores/ Herpes/ Fever Blisters/ Shingles If yes, how frequently? Circle one.

- Less than 1 per year
- 1-3 per year
- 3-5+ per year

SUN HISTORY AND LIFESTYLE

How often do you?

Work Outside Y/N Frequently/ Occasionally/ Rarely/ Never

Use Sunscreen Y/N Frequently/ Occasionally/ Rarely/ Never

Use Tanning Beds Y/N Frequently/ Occasionally/ Rarely/ Never

Smoke or Use Tobacco Products Y/N Frequently/ Occasionally/ Rarely/ Never

YOUR CURRENT HOME SKINCARE REGIMEN

Cleanser _____ Toner _____ Moisturizer _____
EyeCream _____ Exfoliator _____ SPF _____ Makeup _____
Other _____

I, _____ agree that the information above is correct and true to the best of my knowledge. I understand that this information will directly affect the outcome and results of my treatments at MademEl Medical Aesthetics

Signature _____ Printed Name _____ Date _____

CANCELLATION POLICY

At MademEl Medical Aesthetics, we understand that situations arise and appointments need to be cancelled. To provide the best in customer care for all of our valued clients, we require a minimum 24-hour cancellation notice. Clients that do not honor their scheduled appointment will be charged a cancellation fee as follows:

More than 24-hour notice: Service will be cancelled at no charge

Less than 24-hour notice: 50% of the service will be charged

Failure to show without notice or same-day cancellations: 100% of the service will be charged

There is a \$200 **non-refundable** deposit for Botox/ Filler appointments. This \$200 will be directly applied to the procedure if the appointment is kept. If said appointment is cancelled in less than 24 hours, or there is failure to show without notice, the \$200 fee will be kept by MademEl Medical Aesthetics.

Payment of cancellation fee must be paid before a new appointment can be scheduled. This cancellation policy allows us the time to inform our stand-by clients of any availability. Thank you for your cooperation in this matter and your consideration for other clients of MademEl Medical Aesthetics.

I have read and understand this cancellation policy, and I agree to be charged the cancellation fee for any infraction of this cancellation policy.

Signature of Patient: _____

Printed Name: _____

Today's Date: _____

Consent for Release of Medical and Financial Information to

FAMILY MEMBERS

I, _____ authorize MademEl Medical Aesthetics and its staff to use and disclose my medical and/or financial information to the following person(s):

NAME _____ PHONE _____

RELATIONSHIP _____



Consent to Photograph

Choose one of the following:

I, _____, **give** MadEmEl Medical Aesthetics permission to use/post my photo(s) on the following social media outlets: Instagram, Facebook, and MadEmEl's website. The photos have been shown to me and I approve.

I, _____, **do not give** MadEmEl Medical Aesthetics permission to use/post my photo(s)

Signature/Date