

# Lasting Looks of Sarasota

3300 S. Tamiami Tr. #6  
Sarasota, FL, 34239  
(941) 539-7990

## Medical/Skincare History & Informed Consent

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Purpose of visit ( circle):

Massage    Skin care    Permanent Make-up    Microdermabrasion    Vascular    Non-surgical face Lift    Consultation

## **Medical History:**

Are you presently under a doctors care?

Name/Phone: \_\_\_\_\_ Explain? \_\_\_\_\_

Current medications/supplements. \_\_\_\_\_

Metal implants? No \_\_\_\_\_ Yes \_\_\_\_\_ how old & type \_\_\_\_\_

Facial surgery? \_\_\_\_\_ Dr. \_\_\_\_\_

Have you ever tested positive for:

**AIDS/HIV?** No \_\_\_\_\_ Yes \_\_\_\_\_

**Tuberculosis?** No \_\_\_\_\_ Yes \_\_\_\_\_

**Or Hepatitis?** No \_\_\_\_\_ Yes \_\_\_\_\_: type \_\_\_\_\_

Please check all that apply to your health or usage:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Accutane                          | <input type="checkbox"/> Emphysema                             | <input type="checkbox"/> Pace Maker        |
| <input type="checkbox"/> Allergies                         | <input type="checkbox"/> Epilepsy                              | <input type="checkbox"/> Pregnant/nursing  |
| <input type="checkbox"/> Birth Control Pills               | <input type="checkbox"/> Headaches/Migraines                   | <input type="checkbox"/> Rashes            |
| <input type="checkbox"/> Bruise easily, cuts               | <input type="checkbox"/> Heart Problems/disease                | <input type="checkbox"/> Retin A           |
| <input type="checkbox"/> Cancer _____                      | <input type="checkbox"/> High Blood Pressure                   | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Herpes, cold sores, fever blister     | <input type="checkbox"/> Stretch Marks✖    |
| <input type="checkbox"/> Eczema                            | <input type="checkbox"/> Hormone Imbalance/replacement therapy | <input type="checkbox"/> Stretch Marks     |
| <input type="checkbox"/> Irregular pigmented moles/growths | <input type="checkbox"/> Keloids, pigmented scars              | <input type="checkbox"/> Thyroid condition |
|  | <input type="checkbox"/> Lupus                                 | <input type="checkbox"/> Varicose veins    |
|  |  | <input type="checkbox"/> Warts             |

Do you consume any of the following & **how often?**( ie. 1X wk, 1X day etc.)

Alcohol: \_\_\_\_\_ How much water do you drink daily? \_\_\_\_\_

Nicotine: \_\_\_\_\_ Describe your sun exposure? Rare, moderate, frequent?

NutraSweet: \_\_\_\_\_ Describe your stress level. (scale of 1-10) \_\_\_\_\_

Caffeine: \_\_\_\_\_

Sodas: \_\_\_\_\_

## **Your Skin**

How do you describe your skin type? Balanced \_\_\_\_\_ Oily \_\_\_\_\_ Dry \_\_\_\_\_ Mature \_\_\_\_\_ Sensitive \_\_\_\_\_

Current conditions? Rosacea \_\_\_\_\_ Acne \_\_\_\_\_ Eczema \_\_\_\_\_ Melanoma \_\_\_\_\_

What product brand(s) are you currently using? \_\_\_\_\_

Do you have any product allergies? No \_\_\_\_\_ Yes, \_\_\_\_\_

Allergies to shrimp/shellfish, aspirin? No \_\_\_\_\_ Yes, \_\_\_\_\_

**Circle** all that apply to your current regimen:

Do you: cleanse, tone, moisturize, exfoliate, eye cream, SPF, other\_\_\_\_\_

Do you experience:

oily shine during the day? Yes/No

breakouts? Yes/No How often?\_\_\_\_\_

burn easily? Yes/No

Blush easily? Yes/No

Tendency to redness often? Yes/No

What are your three major concerns or goals with your skin?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### **Informed Consent**

I consent to undergo skin care/massage treatments knowing that results vary from person to person. Benefits and results are dependent upon my "home care" and general health as it relates to my treatment and as instructed by my practitioner. Furthermore, I understand that optimum results are achieved only by consistent & ongoing treatment in accordance to the treatment plan discussed with my practitioner.

I also agree to the use of before and after progress photos for marketing purposes and understand that my identity will be kept confidential. \_\_\_\_\_ **Initial**, no please \_\_\_\_\_

I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

I acknowledge that I have been informed that allergic reactions, bruising, puffiness, redness or other symptoms can occur occasionally from these therapies and I hereby declare that Lasting Looks of Sarasota, Inc. will not be held accountable should these occur. I also understand that diagnosis of disease, medical conditions and cancer is to be determined by a physician only.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

