Lasting Looks of Sarasota

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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:

- ❑Accutane
- ❑Allergies
- ❑Birth Control Pills
- ❑Bruise easily, cuts
- ❑Cancer_____
- ❑Diabetes
- ❑Eczema
- ❑Irregular pigmented moles/growths
- ❑Emphysema
- ❑Epilepsy
- ❑Headaches/Migraines
- ❑Heart Problems/disease
- ❑High Blood Pressure
- ❑Herpes, cold sores, fever blister
- ❑Hormone Imbalance/replacement therapy
- ❑Keloids, pigmented scars
- ❑ Lupus
- ❑Pace Maker
- ❑Pregnant/nursing
- ❑Rashes
- ❑Retin A
- ❑Seizures
- ❑Stretch Marks✠
- ❑Stretch Marks
- ❑Thyroid condition
- ❑Varicose veins
- ❑Warts

Do you consume any of the following & **how often**?(ie. 1X wk, 1X day etc.)
Alcohol:_____
Nicotine:_____
NutraSweet:_____
Caffeine:_____
Sodas:_____

How much water do you drink daily?_____
Describe your sun exposure? Rare, moderate, frequent?
Describe your stress level. (scale of 1-10) _____

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:_____

LASTING LOOKS
OF SARASOTA
nutritional skin care and permanent make-up
Nurture and Nourish the way Nature intended