CosMedicLaserMD
DEEPA MACHA, MD

Name:	Date(m/d/y): / /	Occupation:
Address:	Home Phone:	Date of Birth (m/d/y): / /
City:	State: Zip Code:	Email:
Cell:	Contact by: ☐ Text ☐ Cell	Emergency Contact:
How did you hear about us: _____		Referral Name:

General Health

1. Rate your level of stress: (5 = highest, 1 = lowest) ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
2. Are you pregnant or nursing? ☐ No ☐ Yes Are you breastfeeding? ☐ No ☐ Yes
3. Do you wear contact lenses? ☐ No ☐ Yes
4. Do you smoke? ☐ No ☐ Yes How many cigarettes per day? ___
5. Please list any accidents or surgeries in the last 9 months: _____
6. Do you have any metal implants, a pacemaker or body piercings? ☐ No ☐ Yes
7. Do you have any **ALLERGIES** to medications? ☐ No ☐ Yes, explain: _____
8. List any (prescription or over the counter) medications you are currently taking below: ☐ Not applicable

Prescription Medications:	Over the Counter Medications:

Medical Health History (check all that apply)

☐ Heart Condition	☐ Lymph Edema	☐ Herpes/Shingles/Cold Sores	☐ High Blood Pressure
☐ Numbness/Tingling	☐ Sinus Problems	☐ Asthma	☐ Chronic Pain
☐ Rashes	☐ Jaw Pain/TMI	☐ Blood Clots	☐ Constipation
☐ Diabetes	☐ Gas/Bloating	☐ Headaches	☐ Arthritis
☐ Broken/Fractured Bones	☐ Pregnancy (___weeks)	☐ Fatigue/Sleep Disorder	☐ Depression/Anxiety
☐ Seizure/ Epilepsy	☐ Hemophilia	☐ Undergoing Cancer Treatment	☐ Seasonal allergies

☐ Other (explain): _____

Skin Care

1. Are you under the care of a dermatologist, cosmetic dermatologist, or plastic surgeon? ☐ No ☐ Yes
2. Do you use: ☐ Accutane (in the last year) ☐ Retin-A ☐ Renova ☐ Adapalene ☐ Not applicable
   ☐ Other prescription skin products: _____
3. Have you had a: ☐ Chemical Peel ☐ Microdermabrasion ☐ Botox ☐ Filler ☐ Laser ☐ Hydrafacial ☐ Microneedling
   ☐ Not applicable ☐ Other resurfacing treatments: _____
4. Are you currently using any products that contain: ☐ Glycolic Acid ☐ Lactic Acid ☐ Hydroxy Acid ☐ Vitamin A
   ☐ Retin-A ☐ Not applicable
5. Do you have any skin sensitivities or irritants? ☐ No ☐ Yes, explain: _____
6. Do you have any history of: ☐ Keloids ☐ Hyperpigmentation ☐ Acne ☐ Not applicable

This Form is Double Sided

| 4900 Jackson Road | Ann Arbor, MI 48103 | 734-249-8722 |

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Skin Maintenance
Products You Use: ☐ Soap ☐ Cleanser ☐ Toner ☐ Moisturizer ☐ Exfoliator ☐ Not applicable ☐ Masque ☐ Other(s)_____
Skin Type: ☐ Oily/Congested ☐ Dry/Dehydrated ☐ Sensitive/Redness ☐ Acne ☐ Sunburned ☐ Other:_____
Do you have a history of any of the following? ☐ Eczema ☐ Claustrophobia ☐ Melasma ☐ allergy to Iodine or Shellfish ☐ Not applicable ☐ Nickel allergy ☐ Rosacea ☐ Psoriasis ☐ Herpes/Shingles/Cold Sores
Have you been tanning in the last 24 hours? ☐ No ☐ Yes Are you going or coming from vacation? ☐ No ☐ Yes
How would you rate the amount of planned sun exposure treatment? ☐ None ☐ Low ☐ Moderate ☐ High
How long has it been since your last facial? (circle time unit) ____ day(s)/month(s)/year(s) ☐ Never had a facial
What are your skin care goals? ☐ Anti-aging ☐ Controlling Acne ☐ Relaxation ☐ New Skincare Regimen ☐ Treatment of Scars ☐ Maintenance ☐ Pore Size Cleansing ☐ Hydration ☐ Treatment of Hyperpigmentation or Uneven Skin Tone ☐ Other(s):_____ _____

Cancellation Policy:

It is my choice to receive these services from CosMedicLaserMD. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update the staff at CosMedicLaserMD of any changes to my health status. If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee that applies.

Photo Consent:

I hereby authorize CosMedicLaserMD to take photographs and/or digital images of me. I am aware that all reasonable efforts will be made to conceal my identity in these images and that this may not be possible, particularly in images involving the face. I understand that this authorization is voluntary and I may refuse to sign. I understand that I may revoke the authorization at any time by sending a written statement of revocation to ATP Medical Aesthetics. I hereby release Deepa Macha MD, CosMedicLaserMD and its employees from any and all liability connected with the capture, use, or release of my images.

☐ No, I don't agree to have my photos taken ☐ Yes, I agree to have my photos taken

_____ _____ / /

Name Date (m/d/y)

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