SONOMA

SONOMA ORAL & FACIAL SURGERY

7400 South Power Road, Suite 136 • Gilbert, Arizona 85297
480.279.3113 • 480.279.2741

MEDI SPA
HEALTH HISTORY
FACIAL CONSENT FORM

DATE____________________
NAME____
ADDRESS__________________________ CITY ____________ ZIP
PHONE (H)____________________ (C)____________________

WOULD YOU LIKE TO RECEIVE E-MAIL ?(PLEASE MARK ALL THAT APPLY)
__NONE ___ APPOINTMENT CONFIRMATION __SPECIAL OFFERS
E-MAIL ADDRESS____

BIRTHDAY____________________ AGE__________ M___ F___

WHO MAY WE THANK FOR YOUR REFERRAL?
FRIEND________________________
NEWSPAPER________________________
BUSINESS________________________
CURRENT PATIENT________________
EMPLOYEE________________
INTERNET________________
OTHER________________

TO HELP US BETTER DETERMINE YOUR NEEDS,
PLEASE DESCRIBE YOUR SKIN TYPE AND ANY CONCERNS (PLEASE MARK)
__NORMAL __DRY __OILY __ACNE __ACNE SCARS
__THICK __THIN __SAGGY __FIRM __SENSITIVE
__T-ZONE/ COMBINATION __UNEVENNESS __PRONE TO BREAKOUTS
__PSORIASIS __ROSACEA __ECZEMA __MELASMA
__MATURE/WRINKLED __FRECKLED/SUNDAMAGE
__BROKEN CAPILARRIES (TINY VESSELS)
__HYPO/HYPER-PIGMENTATION (LIGHTER OR DARKER SPOTS)

SKIN TONE
__PALE/FAIR __LIGHT __FRECKLED __OLIVE __MED/DARK __BLACK

EYE COLOR
__BLUE __GREEN __BROWN __HAZEL __OTHER____________

HAIR COLOR
__BLONDE/DARK BLONDE __BROWN/DARK BROWN __BLACK __GRAY
__RED

WHAT, IF ANY, IMPROVEMENTS WOULD YOU LIKE TO SEE IN YOUR SKIN?

____

WHAT PRODUCTS ARE YOU CURRENTLY USING IN YOUR REGIMEN?

____

WHAT FACIAL TREATMENT DID YOU HAVE PERFORMED LAST?

____

WHAT DID YOU ENJOY MOST AND LEAST ABOUT THE TREATMENT?
MOST______________________ LEAST______________________

WHAT ARE YOU MOST INTERESTED IN TODAY?
___RELAX/PAMPER ___DEEP CLEANSE/PURIFY
___ANTI-AGING/RE-NEW APPEARANCE ___INFORMATION/MAINTAIN SKIN HEALTH

DO YOU LIKE TO HAVE A LOT OF INFORMATION OR QUIET DURING TREATMENT?
___TALK AS YOU GO ___LITTLE INFO HERE AND THERE ___SILENCE

DO YOU USUALLY BREAKOUT AFTER A FACIAL? ___YES ___NO ___DON'T KNOW

SPF DAILY USE (PLEASE MARK ALL THAT APPLY
___SPF 15 ___SPF 15+ ___SPF30+ ___ITS IN MY (MAKE-UP/MOISTURIZER)
___DO NOT USE ON REGULAR BASIS

HAVE YOU HAD/USED ANY OF THE FOLLOWING IN THE LAST 3 WEEKS?
___LAID IN THE SUN MODERATE/EXTREME
___TANNING BOOTH MODERATE/EXTREME
___USED SELF TANNER DAILY/WEEKLY

ARE YOU CURRENTLY TAKING ANY MEDICATION ORALLY OR TOPICALLY?
IF SO, PLEASE LIST
MEDICATION______________________ REASON______________________
MEDICATION______________________ REASON______________________
MEDICATION______________________ REASON______________________

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 6 MONTHS?
___ACCUTANE ___RETIN-A / RENOVA ___RETINOL
___GLYCOLIC ACID ___ASPIRIN / BLOOD THINNERS ___ARTHRITIC GOLD

DO YOU CURRENTLY USE PRODUCTS CONTAINING AHA OR GLYCOLIC? ___YES ___NO
IF SO, WHICH ONES AND FOR HOW LONG? ______________________

ARE YOU CURRENTLY UNDER A PHYSICIANS CARE?
PHYSICIANS NAME______________________ REASON______________________
DERMATOLOGIST______________________ REASON______________________

DO YOU HAVE ANY ALLERGIES TO ANY OF THE FOLLOWING?
FOODS____
DRUGS____

DO YOU CURRENTLY USE WAX, ELECTROLYSIS OR DEPILATORIES ON YOUR FACE?
___YES ___NO WHEN WAS YOUR LAST TREATMENT?

HEALTH HISTORY
PLEASE MARK ALL THAT APPLY TO PAST OR PRESENT

___AIDS/HIV
___ARTHRITIS
___DIABETES/GESTATIONAL
___BONE INJURY/RODS/IMPLANT
___SKIN CONDITION/DISORDER
___DIGESTIVE PROBLEMS
___FATIGUE
___KELOID SCARS
___CURRENTLY BREASTFEEDING
___MUSCLE PAIN/SPASM
___HIGH / LOW BLOOD PRESSURE
___HEPATITIS A / B / C
___JOINT INJURY/REPLACEMENT
___MENOPAUSAL SYMPTOMS
___STROKE
___ASPIRIN ALLERGY / SENSITIVE
___THYROID
___NECK INJURY
___ASTHMA
___BRUISE EASILY
___FYBROMYALGIA
___CANCER/SKIN/OTHER________________
___CIRCULATION/BLOOD CLOTS
___EPILEPSY/SEIZURES
___CONTACT LENSES
___LUPUS
___PREGNANT/POSSIBLE (DUE DATE)________
___HEART CONDITION___________________
___HEADACHES / MIGRAINS
___OTHER INFECTIONS___________________
___SLEEP PROBLEMS / INSOMNIA
___SPINAL PROBLEMS
___SWELLING
___TUMORS / GROWTHS
___VARICOSE VEINS
___RECENT SURGERY___________________
___HERPES OUTBREAKS / HIVES / COLD SORES
HOW OFTEN? ________ LAST BREAKOUT? ____________ AREA?_________
___OTHER____

IS THERE ANYTHING ELSE OUR PROVIDING STAFF SHOULD KNOW ABOUT YOU?
____

FACIAL CONSENT AGREEMENT
I AFFIRM THAT I HAVE STATED ALL OF MY KNOWN MEDICAL CONDITIONS AND HAVE ANSWERED ALL QUESTIONS HONESTLY. I AGREE TO KEEP MY MEDICAL PROFILE UPDATED AND UNDERSTAND THERE SHOULD BE NO LIABILITY TO SONOMA MEDI SPA SHOULD I FAIL TO DO SO.

SIGNATURE______________________________ DATE ___/___/____

CONSENT TO TREAT A MINOR
I GIVE MY CONSENT TO A LICENSED AESTHETICIAN FOR THE MEDI SPA AT SONOMA ORAL & FACIAL SURGERY TO PERFORM FACIAL TREATMENTS TO MY CHILD OR DEPENDENT AS THEY DEEM NECESSARY.

SIGNATURE______________________________ DATE___/___/____

SONOMA

SONOMA ORAL & FACIAL SURGERY

7400 South Power Road, Suite 136 • Gilbert, Arizona 85297
480.279.3113 • 480.279.2741

Client Name: ____________________ Date: ____________

Score: ____________

		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	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 sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Add above column for Total Score:	Match your total score with the corresponding skin type:	Fitzpatrick Skin Type
	0-7	I
	8-16	II
	17-25	III
	26-30	IV
	Over 30	V-VI

Oral / Maxillofacial Surgery: *wisdom teeth • extractions • dental implants • bone grafting • facial/oral trauma facial reconstruction • orthognathic surgery • pre-prosthetic surgery • TMJ • apicoectomies • hospital consultations*
Facial Cosmetics: *botox and soft tissue fillers • laser resurfacing • hair and mole removal • hard and soft tissue procedures*
Oral Pathology Services: *patient consultations • biopsies • excision/reconstruction*
Anesthesia Services: *general anesthesia • IV sedations • nitrous oxide • local anesthesia*