Client Information and Health History

Name ____ Date ____________________

Home Address ____

City ________________________________ State ________________ Zip Code ____________________

Home Phone ______________________________ Cell Phone __________________________________

Emergency Contact Name and Phone ____

Date of Birth ___________________ Age __________ Occupation ______________________________

Email ____

Would you like to be notified of our current specials via email? (Please Circle) YES NO

How were you referred to us? ____

Medical History

Are you currently under the care of a physician? ( ) Yes ( ) No

Are you currently under the care of a dermatologist? ( ) Yes ( ) No

Do you have any history of livido reticularis, which is an auto immune disease in which the blood vessels are constricted, or narrowed, resulting in mottled discoloration on large areas of the legs or arms?

( ) Yes ( ) No

Do you have a history of erythema ab inge, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irradiation? ( ) Yes ( ) No

Do you have any of the following medical conditions? (Please check all that apply)

( ) Cancer ( ) High Blood Pressure ( ) Keloid Scarring ( ) Hormone Imbalance

( ) Diabetes ( ) Frequent Cold Sores ( ) Hepatitis ( ) Thyroid Imbalance

( ) Herpes ( ) Seizure Disorder ( ) HIV/AIDS ( ) Skin Disease/Skin Lesions

( ) Arthritis ( ) Any Active Infection ( ) ALS ( ) Blood Clotting Abnormalities

( ) Myasthenia Graves Lamber-Eaton Syndrome ( ) Neuromuscular Disorders

Do you have any other heath problem or medical conditions? Please List: __________________________

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What oral medications are you presently taking? ( ) ACCUTANE ( ) Birth Control ( ) Hormones

( ) Others: ____

Have you ever used ACCUTANE? ( ) YES ( ) NO If yes, when did you last use it? __________________

What topical medications or creams are you currently using? ( ) Retin A

( ) Others: ____

Have you ever had Laser Hair Removal? ( ) Yes ( ) No

Have you ever used any of the following hair removal methods in the past six weeks?

( ) Shaving ( ) Waxing ( ) Electrolysis

( ) Plucking/Tweezing ( ) Stringing ( ) Depilatories

Have you had any recent sun exposure that changed the color of your skin? ( ) Yes ( ) No

Have you recently used self-tanning lotions or treatments? ( ) Yes ( ) No

Do you form thick or raised scars from cuts or burns? ( ) Yes ( ) No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ( ) Yes ( ) No

If yes to any of the above, please explain. ____

For our female clients:

Are you pregnant or trying to become pregnant? ( ) Yes ( ) No

Are you using contraception? ( ) Yes ( ) No

Are you breastfeeding? ( ) Yes ( ) No

Allergies

Have you ever had an allergic reaction to any of the following? (Please check all that apply)

( ) Food ( ) Cosmetics ( ) Cow's Milk Protein

( ) Aspirin ( ) Lidocane ( ) Hydrocortisone

( ) Latex ( ) Hydroquinone or Skin Bleaching Agents ( ) Other _________________________

I certify that the preceding medical, person and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, aesthetician, doctor or nurse of my medical and health conditions up to date. This history, as a current medical history, is essential for the caregiver to execute the appropriate treatment procedures.

Signature ____ Date ___________________