CLIENT INFORMATION & MEDICAL HISTORY

To provide appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth ___/___/___ Age _____ Occupation _____

Home Address_____ City_____ State___ Zip Code _____

Email address: _____

Home Phone (___) _____ Cell Phone (___) _____

Emergency Contact Name and Phone _____ (___) _____

How were you referred to us?_____

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans

II Always burns, sometimes tans

III Sometimes burns, always tans

IV Rarely burns, always tans

V Brown, moderately pigmented skin

VI Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? oNo oYes
If yes, for what: _____
Are you currently under the care of a dermatologist? oNo oYes
If yes, for what:_____

Do you have a history of a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? oYes oNo

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

High blood pressure	Arthritis	HIV/AIDS	Keloid scarring
Diabetes	Cancer	Herpes	Frequent cold sores
Skin disease/Skin lesions abnormalities	Hepatitis	Seizure disorder	Blood clotting
Hormone imbalance	Thyroid imbalance		Any active infection

Do you have any other health problems or medical conditions? (Please list):

_____

_____

Have you ever had an allergic reaction to any of the following?

(Please circle all that apply and describe the reaction you experienced)

Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching

_____

Do you have any allergies? _____

MEDICATIONS

What oral medications are you presently taking? Birth control pills Hormones

Others (Please list)_____

Are you on any mood altering or anti-depression medication? o No o Yes

Have you ever used Accutane? o No o Yes If yes, when did you last use it? _____

What topical medications or creams are you currently using? o RetinA , oOthers (Please list):

_____

What herbal supplements do you use regularly?

_____

_____

HISTORY

Have you ever had laser hair removal? o No o Yes

Have you 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 tanning or sun exposure that changed the color of your skin? o No o Yes

Have you recently used any self-tanning lotions or treatments? o No o Yes

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

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? o No o Yes If yes, please describe:

_____

For our female clients:

Are you pregnant or trying to become pregnant? o No o Yes

Are you breastfeeding? o No o Yes

Are you using contraception? o No o Yes

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor, or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date: _____