Client Information/Medical History

Please complete the following questionnaire to allow us to provide you with the most appropriate treatment. All information is strictly confidential.

Client Name____Today's Date___________
Date of Birth_______________Age_______Occupation_________________________
Home Address_____________________________City____________State____Zip_____
Home Phone_______________Work Phone_______________Cell Phone_______________
Emergency Contact-Name & Phone Number_______________________________________
E-mail Address____
How were you referred to us?____

<u>Medical History</u>

Are you currently under the care of a physician or dermatologist? YES/NO
If YES, for what reason?____
Are you currently taking any medications-prescription or other? YES/NO
If YES, please list all medications____
Are you currently using Accutane or Retin A Products?___________________
Have you had any surgeries within the last year? YES/NO
If YES, for what reason?____
Please check all medical conditions that apply to you:

Cancer___Lupus___Epilepsy____Diabetes____High Blood Pressure____
Seizure Disorder____HIV/AIDS____Hepatitis____Heart Condition____
Tuberculosis____Cold Sores____Herpes (Genital)____Hemophilia____
Contact Lens____Pacemaker____Hearing Aid____Metal Pins____
Permanent Make Up____Skin Disease or Lesions____Psoriasis____
Dermatitis____Any Active Infection____Keloids____Scarring____
Burns____Arthritis____Fibromyalgia

Are you pregnant? YES/NO   Are you taking birth control pills? YES/NO
Are you pre or post menopausal? YES/NO
Are you currently taking hormone therapy? YES/NO

Please list any other medical conditions or health problems:____

Have you used any of the following hair removal methods in the last six weeks?
Shaving___ Waxing___ Electrolysis___ Tweezing/Plucking___ Depilatories___ Laser___

Have you been exposed to the sun in the past four weeks? YES/NO
Have you been in the tanning bed within the last six weeks? YES/NO
Have you used self tanners or any lotion to darken your skin within the last six weeks? YES/NO
Do you form thick or raised scars from cuts or burns? YES/NO
Have you ever experienced Hyper-Pigmentation (darkening of the skin)? YES/NO
Hypo Pigmentation? (Lightening of the skin)?YES/NO

What treatments are you interested in receiving?
____

What areas are you interested in treating?
____

What treatments have you previously received?
____

I certify that the preceding information is true and correct. I am aware that it is my responsibility to inform my technician or esthetician of any changes in my medical history or health conditions and to update this history as needed. A current medical history is essential in providing you with the appropriate treatment procedures.

<u>Please inform your technician of any changes in your medical history, medications and any sun exposure, tanning bed use and/or use of self tanners at each visit.</u>

Client Signature________________________________ Date_____________
Technician____________________________________Date______________