Client Information & Medical History

Personal History

Client Name ______________________________________ DOB ________________

Home Address _______________________________ City ____________________

Zip Code ___________ Emergency Contact ______________________________

Home Phone ________________________ Work Phone _______________________

Email Address ____

How were you referred to us? ____

Which of the following best describes your skin type? (Please check box by 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? ___________________________

If yes, for what ____

Are you currently under the care of a dermatologist? _________________________

If yes, for what ____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ___________________

Do you have any of the following medical conditions? (check boxes)

Cancer _____ Diabetes _____ High blood pressure _____ Herpes _____ Arthritis _____

Frequent cold sores _____ HIV/AIDS _____ Keloid Scarring _____ Hepatitis _____

Skin disease/Skin lesions _____ Seizure disorder _____ Hormone imbalance _____

Thyroid imbalance _____ Blood clotting abnormalities _____ 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? (check boxes)

Food _____ Latex _____ Aspirin _____ Lidocaine _____ Hydrocortisone _____

Hydroquinone or skin bleaching agents _____ Others ___________________

Medications

What oral medications are you presently taking? Birth Control Pills ______________

Hormones_________________________ Others ______________________________

Are you on any mood altering or anti-depression medication? ____________________

Have you ever used Accutane? _______ If yes, when did you last use it? ____________

What topical medications or creams are you currently using? RetinA _____ Others _____

What herbal supplements do you use regularly? ________________________________

History

Have you ever had laser hair removal? ______

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? ___

Have you recently used any self-tanning lotions or treatments? _____

Do you form thick or raised scars from cuts or burns? _______

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? _______ If yes, please describe ___________

____

For our Female Clients:

Are you pregnant or trying to become pregnant? _______ Are you breastfeeding? _______

Are you using contraception? _______

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 ________________