CLIENT INFORMATION & MEDICAL HISTORY

All information is strictly confidential

PERSONAL HISTORY

Client Name _____ Today's Date _____

Home Address_____

City_____ State_____ Zip _____ Birth date_____

Best daytime phone (_____)_____Alternate phone (_____) _____

Would you like to receive special discount offers via email? ☐Yes ☐No

Email address_____

Emergency Contact Name and Phone _____

How did you hear about 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

How often do you use tanning salons or sun bathe? ☐Once a week ☐Once a month ☐Seldom/Never

MEDICAL HISTORY

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

If yes, for what:_____

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

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? ☐Yes ☐No

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

☐Cancer ☐Diabetes ☐High blood pressure ☐Herpes ☐Arthritis ☐Frequent cold sores ☐HIV/AIDS

☐Hepatitis ☐Keloid scarring ☐Skin disease/Skin lesions ☐Seizure disorder ☐Hormone imbalance

☐Thyroid imbalance ☐Blood clotting abnormalities ☐Any active infection

Please explain _____

_____

PLEASE CONTINUE ON BACK PAGE

Do you have any other health problems or medical conditions we should know about?

Please list: _____

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

☐Food ☐Latex ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Hydroquinone or skin bleaching agents

Explain reaction: _____

MEDICATIONS

Have you ever taken **Accutane**? ☐Yes ☐No If yes, when did you last use it?_____

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

Please list: _____

Are you on any mood altering or anti-depression medication? ☐Yes ☐No What type? _____

What topical medications or creams are you currently using? ☐ Retin-A® ☐Others

Please list: _____

What herbal supplements do you use regularly?_____

SKIN HISTORY

Have you had any recent tanning or sun exposure that changed the color of your skin? ☐Yes ☐No

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

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

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

☐Waxing ☐Electrolysis ☐Plucking ☐Tweezing ☐Stringing ☐Depilatories

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

Do you get hyper-pigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin) or marks after physical trauma? ☐Yes ☐No

Please describe: _____

For our female clients:

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

Are you breast feeding? ☐Yes ☐No

Are you using contraception? ☐Yes ☐No

ACKNOWLEDGEMENT:

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.

Client Signature_____ Date: _____

Medical Director_____ Date: _____

Reviewed treatment procedure and approved to proceed