Client Information & Medical History

All information is strictly confidential

Personal History

Name:_______________________________________ Pronouns __________ Today's Date ______________

Date of Birth ______________________ Age ____________ Occupation ___________________________

Home Address ____

City __________________________________ State _____________ Zip ____________________

Phone________________________________ Work ______________________________________

Emergency Contact Name & Phone ____

How were you referred to us? ____

Which of the following best describes your skin type? (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? ____ 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 ____ High Blood Pressure ____ HIV/AIDS ____ Hormone imbalance

____ Arthritis ____ Frequent cold sores ____ Keloid scarring ____ Any active infection

____ Herpes ____ Seizure disorder ____ Diabetes ____ Hepatitis

____ Skin disease / Skin lesions ____ Blood clotting abnormalities

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 check **all** that apply and describe the reaction you experienced):

____ Food ____ Latex ____ Aspirin ____ Lidocaine ____ Hydrocortisone

____ hydroquinone or skin bleaching agents ____ Other

Reaction(s) experienced ____

____

Medications

What oral medications are you presently taking?

____ Birth control pills ____ Hormones ____ Other (please list):

____

Are you taking any mood-altering or anti-depression medication? ____ Yes ____ No

Have you ever used Accutane? ____ Yes ____ No If Yes, when did you last use it? _____________

Are you using any topical medications or creams? _____ Retin-A® ____ Other (please list):

____

Please list any herbal supplements you regularly use: ____

____

History

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

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? __ Yes __ No

Have you recently used any 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, please describe: ____________________

____

____

For Our Female Clients

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

Are you breastfeeding? ____ Yes ____ No

Are you using contraception? ____ Yes ____ No

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 ___________________