Client Medical History

Date: _____ Name: _____

Date of Birth: _____ Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail address: _____

Single: ❑ No ❑ Yes Married: ❑ No ❑ Yes If yes, anniversary date: _____

Occupation: _____ Emergency Contact: _____

Does your job require that you work outdoors? ❑ No ❑ Yes

Referred by: _____

What procedures are you interested in? Check all that apply

❑ Laser hair removal	❑ Facial	❑ Skin tightening	❑ Tatoo removal
❑ Botox/Dysport	❑ Dermal fillers	❑ PRP	❑ Teeth whitening
❑ Heart problems	❑ Diabetes	❑ HIV	❑ Lupus

What would you like to achieve from your treatments: _____

_____

List all medications and supplements: _____

_____

_____

Please check any condition that you currently have or have had in the past:

❑ Heart problems	❑ Diabetes	❑ HIV	❑ Lupus
❑ Auto immune disease	❑ Bruise Easily	❑ Poor wound healing	❑ Asthma
❑ Eczema	❑ Psoriasis	❑ Vitiligo	❑ Keloid scarring
❑ Pacemaker	❑ Metal implant	❑ Seizure	❑ Epilepsy
❑ Anxiety	❑ Depression	❑ Hyper thyroid	❑ PCOS
❑ Excessive hair growth	❑ Excessive hair loss	❑ Permanent makeup	❑ Totoo

Client Initial_____

❑ MS ❑ ALS ❑ Bell's Palsy ❑ Cold sores

❑ Shingles ❑ High blood pressure ❑ Varicose veins

Your Skin Care

1) Have you ever had a facial treatment before? ❑ No ❑ Yes If yes, when: _____

2) Which of the following best describes your skin when exposed to the sun for 30 minutes & no SPF:

❑ Always burns easily, never tans with very pale skin tone
❑ Always burns, tans with a hint of color with very pale skin tone
❑ Burns initially, tans gradually with light skin tone
❑ Can burn and can tan with olive/gold skin tone
❑ Rarely burns with brown skin tone
❑ Rarely burns with very deeply pigmented skin tone

Your ethnicity: _____

4) Do you have any special skin problems or concerns pertaining to your face or body? ❑ No ❑ Yes

If yes, please specify: _____

5) Have you ever had chemical peels, laser or microdermabrasion? ❑ No ❑ Yes

In the last month? ❑ No ❑ Yes If yes please describe: _____

6) Do you use Retin-A, Renova, Hydroquinone, Hydroxyl Acid or Retinol/vitamin A derivative products?

❑ No ❑ Yes If yes, please describe: _____

_____

7) Have you used any of the above products in the last 3 months? ❑ No ❑ Yes

8) Have you used an acne medication? ❑ No ❑ Yes If yes when? _____

What type? _____

9) What skin care products are you currently using? (List brand): _____

_____

10) Have you recently used any self-tanning lotions, creams or treatments: ❑ No ❑ Yes

Please specify: _____

11) Have you used any of the following hair removal methods in the past 4 weeks? ❑ No ❑ Yes

If yes, where on your body? _____

Please check all that apply:

Client Initial_____

❑ Shaving ❑ Waxing ❑ Electrolysis ❑ Plucking

❑ Tweezing ❑ Threading ❑ Depilatories ❑ Laser

12: What areas on concern do you have regarding your skin? Check all that apply:

❑ Breakouts/acne ❑ Blackheads/whiteheads ❑ Excessive oil/shine ❑ Rosacea

❑ Dehydrated skin ❑ Broken capillaries ❑ Redness/ruddiness ❑ sun spots

❑ Puffiness ❑ Dark circles ❑ Uneven skin tone ❑ Sun damage

❑ Wrinkles/fine lines ❑ Dull/dry skin ❑ Flaky skin

Other: _____

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

❑ Cosmetics ❑ Medicine ❑ Food ❑ Animals

❑ Sunscreen ❑ Iodine ❑ Pollen ❑ AHA

❑ Fragrance ❑ Salicylic acid ❑ Shellfish ❑ Latex

❑ Drugs ❑ Sun ❑ Numbing agents

If yes, please explain: _____

_____

14) What SPF do you use on your face? _____ How often/when? _____

15) What SPF do you use on your body? _____ How often/when? _____

16) In the last 2 weeks, have you had any tanning bed or sun exposure? ❑ No ❑ Yes

Did you tan or burn? Please specify: _____

_____

17? In the last 2 weeks, have you had injections such as Botox™, Restylane™ or Collagen? ❑ No ❑ Yes

Please specify: _____

Client Initial_____

Female Clients Only:

18) Are you taking oral contraceptives? ❑ No ❑ Yes

Please specify: _____

19? Any recent changes to or from your contraceptive treatment? ❑ No ❑ Yes if so, what and when:

_____

20) Are you pregnant or trying to become pregnant? ❑ No ❑ Yes

21) Are you lactating? ❑ No ❑ Yes

22) Any menopause problems? ❑ No ❑ Yes

Please specify: _____

23) Are you undergoing any hormone replacement therapy? ❑ No ❑ Yes

Please specify: _____

Male clients Only:

24) What is your current shaving system? ❑ Wet shave ❑ Electric

25) Do you experience irritation from shaving ❑ No ❑ Yes Ingrown hairs? ❑ No ❑ Yes

24) What is your current shaving system? ❑Wet shave ❑Electric

Future Appointments/Contact:

May we call home, work or cell phone number to confirm future appointments?

❑ No ❑ Yes Preferred method of contact: _____

May we contact you via email to confirm appointments and send our promotions? ❑ No ❑ Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from your treatment that may be irreversible. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

Client Signature: _____

Client Initial_____