Client Information and Medical History

PERSONAL HISTORY Today's Date_____

Name_____ Date of Birth_____

Address_____City_____State_____Zip_____ Occupation_____

Home_____ Work_____ Cell_____

Referred By_____ Emergency Contact_____ Email_____

Which of the following best describes your skin type? (Please circle only one)

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

Skin Type (Please check only one) __Normal __Dry __Oily __Combination

MEDICAL HISTORY

Currently under the care of a physician? ____Yes ____No If yes, for what?_____

Currently under the care of a dermatologist? ____Yes ____No If yes, for what?_____

History of erythema abigne,a persistant skin rash produced by prolong or repeated exposure to moderately intense heat or infrared irritation?___Yes___No

Do you have a history of any of the following medical conditions? **Please check all that apply**

__Cancer __Diabetes ___High Blood Pressure___Cardiac Disorder __Herpes __Arthritis __Cold Sores __HIV/AIDS __Keloid Scarring __Skin lesion/disease

__Seizure Disorder __Hepatitis __Hormone Imbalance __Immune Imbalance ___Thyroid Imbalance___ Blood Clotting Abnormalities __Any Active Infection

Any other health or medical conditions?_____

Allergic Reactions: __Food __Latex __ Aspirin __Lidocaine __Hydrocortisone __Hydroquinone or skin bleaching agents
__Other_____

Oral medications you are presently taking?_____

Are you currently on any mood altering or depression medication? _____Yes __No If yes_____Have you ever used Accutane? __Yes __No

Topical medications or creams you are currently using? __Retin A __Others_____Herbal supplements used regularly_____

What are your main concerns or changes you wish to adress?_____

HISTORY

Have you ever had laser hair removal?___Yes___NoHair removal methods in the past 6 weeks?___shaving___wax___Electro___Pluck___Tweeze

Have you used tanning bed or sun exposure that changed skin color?___Yes___No Have you used 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_____

FEMALE CLIENTS ONLY

Are you pregnant or trying to become pregnant? __Yes __No Breastfeeding? __Yes __No Birth Control? __Yes___No Hormones? __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 tech, 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_____