Client Medical History

Date: _____ Name: _____

Date of Birth: _____ Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail address: _____

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

○ brown spots or redness ○Toxin Injection ○Dermal filler ○Acne ○Skin Resurfacing ○Lines & Wrinkles ○Skin Tightening

What would you like to achieve from your treatments?

_____

List all medications and supplements:_____

_____

List all past cosmetic or facial surgeries:_____

_____

_____

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

○Heart Problem ○Diabetic ○HIV ○Lupus ○Hepatitis ○Auto Immune Disease ○Bruise Easily ○Poor Wound Healing ○Claustrophobic ○Asthma ○Eczema ○Psoriasis ○Vitiligo ○Keloid Scar ○Pacemaker ○Metal Implant ○Seizure ○Epilepsy ○Anxiety ○Depression ○Hyper Thyroid ○PCOS ○Excessive Hair Growth ○Excessive Hair Loss ○Permanent Makeup ○Tattoo ○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, 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: _____

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

If yes, please specify: _____

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

○No ○Yes

If yes, please describe:
_____

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

6) Have you used an acne medication? ○No ○Yes, when? _____

What type? _____

7) What skin care products are you currently using? (List brand)

_____

8) Have you recently used any self-tanning lotions, creams or treatments ○No ○Yes

Please specify: _____

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

If yes, where on your body?_____

Please circle all that apply:

OShaving OWaxing OElectrolysis OPlucking OTweezing OThreading ODepilatories OLaser

10) What areas of concern do you have regarding your skin? Check all that apply

OBreakouts/acne OBlackheads/whiteheads OExcessive oil/shine ORosacea ODehydrated skin

OBroken capillaries ORedness/ruddiness OSun spot/liver spot/brown spot Opuffiness Odark circles

OUneven skin tone OSun damage OWrinkles/fine lines ODull/dry skin OFlaky skin OSagging

Other _____

11) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain) If yes, please explain:
_____

OCosmetics OMedicine OFood OAnimals OSunscreens OIodine OPollen OAHA

OFragrance OSalicylic Acid OShellfish OLatex ODrugs OSun ONumbing agents

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

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

14) In the last 2 weeks, have you had any tanning bed or sun exposure?

Did you tan or burn? ONo OYes

Please specify: _____

15) In the last 2 weeks, have you had injections such as toxins, fillers, or Collagen? ONo OYes

Please specify: _____

Female Clients Only:

16) Are you taking oral contraceptives? ONo OYes

Please specify: _____

17) Any recent changes to or from your contraceptive treatment? ONo OYes If so, what and when:
_____

18) Are you pregnant or trying to become pregnant? ○No ○Yes

19) Are you lactating? ○No ○Yes

20) Any menopause problems? ○No ○Yes

Please specify: _____

21) Are you undergoing any hormone replacement therapy? ○No ○Yes

Please specify: _____

Male Clients Only:

22) What is your current shaving system? ○Wet shave ○Electric

23) Do you experience irritation from shaving? ○No ○Yes Ingrown hairs? ○No ○Yes

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:

_____

Date: _____