CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire. When finished, print it out and bring it with you to your consultation. All information is strictly confidential.

PERSONAL HISTORY

Client Name: Date:

Date of Birth: Occupation:

Home Address:

City: State: Zip Code:

Best Phone Number to Reach You:

Email:

Emergency Contact Name: And Phone:

How Were You Referred to Us:

Do You Regularly Sunbathe or Use Tanning Salons? How Often?

MEDICAL HISTORY

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

If Yes, For What?

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 ❑ Keloid scarring ❑ Skin Disease/Skin Lesions

❑ Seizure Disorder ❑ Hepatitis ❑ Hormone Imbalance ❑ Thyroid Imbalance

❑ Blood Clotting Abnormalities ❑ Any Active Infection

Do you have any other health problems or medical conditions? Please list:

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)

❑ Food ❑ Animal Protein ❑ Aspirin ❑ Lidocaine

❑ Hydrocortisone ❑ Hydroquinone or Skin Bleaching Agents

Which skin type best decribes you? (Choose I-VI from the descriptions below):

SKIN TYPE	SKIN COLOR	COMMON HEREDITARY BACKGROUND	REACTION
I	Pale White	Nordic, Scandinavian (Swedish, Danish)	Always Burns, Never Tans
II	White	Irish, English, Welsh	Usually Burns
III	Light Brown	Asian, Mediterranean	Mildly Burns, Tans Relatively Well
IV	Moderate Brown	Hispanic, Middle Eastern, African American, Native American	Rarely Burns, Tans Well
V	Dark Brown	Hispanic, Middle Eastern, African American, Native American, Southeast Asian	Very Rarely Burns, Tans Easily
VI	Black	African American, Southeast Asian	Least Likely to Burn Tans Very Darkly

MEDICATIONS

What oral prescription medications are you presently taking?

❑ Birth Control Pills ❑ Hormones

❑ Others (It is required that you list all of them):

____

____

____

Are you taking any antibiotics to treat infection? ❑ Yes ❑ No

If so, which? ____

Do you take any medications for heart conditions? ❑ Yes ❑ No

Are you on any mood altering or anti-depression medication? ❑ Yes ❑ No

What topical medications or creams are you currently using? ❑ RetinA ❑ Others

Please List: ____

What herbal supplements do you use regularly?

____

____

HISTORY

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

What concerns do you have about your skin? ______________________________

____

Are you interested in a particular procedure or product? ______________________________

____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional 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: ______________