CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate medical spa treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name____ Today's Date________________

Date of Birth__________________ Age______ Occupation____________________________________

Home ____

City____ State_________ Zip Code_________________

Home Phone (____)__________________ Work Phone (____)____________________________

Emergency Contact Name and Phone____

How were you referred to us?____

Which of the following best describes your skin type? *(Please check 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

Do you regularly use tanning salons or sun bathe? ☐ Yes ☐ No If yes, how often?__________________

MEDICAL HISTORY

Are you currently under the care of a physician or 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	☐ Frequent cold sores	☐ Seizure disorder	☐ Thyroid imbalance
☐ Diabetes	☐ HIV/AIDS	☐ Hepatitis	☐ Any active infection
☐ High blood pressure	☐ Keloid scarring	☐ Hormone imbalance	☐ ALS or neurological condition
☐ Herpes	☐ Skin disease/lesions	☐ Arthritis	☐ 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 ☐ Aspirin ☐ Hydrocortisone

☐ Latex ☐ Lidocaine ☐ Hydroquinone or skin bleaching agents

☐ Others:____

MEDICATIONS

What oral medications are you presently taking? ☐ Birth control pills ☐ Hormones

☐ Others:(Please list): ____
____

Are you on any mood altering or anti-depression medication?

Have you ever used Accutane? ☐Yes ☐ No If yes, when did you last use it? ______________________

What topical medications or creams are you currently using?

☐ Retin-A®

☐ Others:*(Please list)*: ____

What herbal supplements do you use regularly? ____

What skin products do currently you 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 ☐ 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

Please check any areas of concern:

☐ Fine lines and Wrinkles ☐ Skin Texture ☐ Acne Scars/Other Scars

☐ Brown Spots/Sun Damage ☐ Dehydration ☐ Oil/Acne

☐ Submental fat/Double Chin ☐ Redness/Rosacea ☐ Pore Size

☐ Smile lines, Vertical Lip Lines ☐ Removal of Skin Tags or Skin Irregularities

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.

Client Signature: ____ Date __________________

Clinician Signature: ____ Date __________________