

CONTACT INFORMATION

Date: _____

Last Name: _____ First Name: _____ M.I.: _____ Date of Birth: _____ Age: _____

Cell: _____ Work/Home: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone: _____

How were you referred to us? _____

SKIN TYPE

Which of the following best describes your skin type? (please check one)

- | | | | |
|-------------------------------------------------|-------------------------------------------------------|-------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Creamy complexion | <input type="checkbox"/> Always burns, never tans | <input type="checkbox"/> Matte complexion | <input type="checkbox"/> Rarely burns, always tans |
| <input type="checkbox"/> Light complexion | <input type="checkbox"/> Always burns, sometimes tans | <input type="checkbox"/> Brown complexion | <input type="checkbox"/> Rarely burns, deep tan |
| <input type="checkbox"/> Light/Matte complexion | <input type="checkbox"/> Sometimes burns, always tans | <input type="checkbox"/> Black complexion | <input type="checkbox"/> Never burns, deeply pigmented |

MEDICAL HISTORY

Are you currently under the care of a Physician? YES NO

If yes, for what? _____

Are you currently under the care of a Dermatologist? YES NO

If yes, for what? _____

Do you have any of the following medical conditions? (please check all that apply)

- | | | | |
|-----------------------------------------------|--------------------------------------------|-------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Keloid Scarring | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Frequent Cold Sores |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Clotting Abnormalities | <input type="checkbox"/> Skin Disease / Skin Lesions |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Hormone Imbalance |
| <input type="checkbox"/> Any Active Infection | | | |

Have you had any surgery where lymph nodes were removed? YES NO

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

For our female clients:

Are you pregnant or trying to become pregnant? YES NO

Are you breastfeeding? YES NO

Are you using oral contraception? YES NO

ALLERGIES

Have you had an allergic reaction to any of the following?: (please check all that apply & describe the reaction you had)

Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents

Have you ever had a skin reaction to a fragrance? YES NO Or dislike any fragrances? YES NO

Please list any fragrances with issues:

MEDICATIONS

Please list all medications you are currently taking:

Topical medications:

Herbal Supplements:

Have you ever used Accutane? YES NO If yes, when did you last use it: _____

HISTORY

Have you used any of the following for hair removal in the last six weeks?

Shaving Waxing Electrolysis Plucking/Tweezing Threading 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 similar treatments? YES NO

Do you form thick raised scars from cuts or burns? YES NO

Have you ever had Hyper-pigmentation (darkening of the skin) or Hypo-pigmentation (lightening of the skin) or marks after physical trauma? YES NO

If yes, please describe:

LIFESTYLE

What type of climate do you live in?

Occupation

Hobbies/Activities

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 Esthetician, Technician, Therapist, Doctor or Nurse of my current medical and health history and to update any current conditions. A current medical history is essential for the caregiver to execute the appropriate treatment procedures. (All information is strictly confidential)

Signature

Date
