CLIENT INFORMATION & MEDICAL HISTORY

In order to provide the most appropriate treatment, we ask that you complete the following questionnaire. All information provided is strictly confidential.

PERSONAL HISTORY

Client Name_____ Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____City_____State_____Zip Code_____

Cell Phone (____)_____Email_____

Emergency Contact Name and Phone_____

How were you referred to us? _____

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

- ☐ 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 sun bathe or use tanning salons? ☐ Yes ☐ No If so, how often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, please provide details:_____
_____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No
If yes, please provide details:_____

Do you have a history of erythema ab igne - 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 mark all that apply)

☐ Diabetes	☐ High blood pressure	☐ Herpes	☐ Arthritis
☐ Frequent cold sores	☐ HIV/AIDS	☐ Keloid scarring	☐ Skin disease/ lesions
☐ Seizure disorder	☐ Hepatitis	☐ Hormone imbalance	☐ Thyroid imbalance
☐ Blood clotting abnormalities		☐ Active infection(s)	☐ Cancer

Do you have any other health problems or medical conditions? ☐ Yes ☐ No If yes, please list: _____

_____

Have you ever had an allergic reaction? ☐ Yes ☐ No If yes, please mark which and list any others, describing the reaction: ☐ Food ☐ Animal Protein ☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone ☐ Hydroquinone or skin bleaching agents Others/ Reactions:_____

_____

MEDICATIONS

What oral prescription medications are you presently taking? (Required to state all, in case of possible interactions) ☐ Birth control pills ☐ Hormones ☐ Others :_____

_____

Do you use antibiotics to treat infections? ☐ Yes ☐ No If yes, please list:_____

_____

Do you take medications for a heart condition? ☐ Yes ☐ No If yes, please list: _____

_____

Are you on any mood altering or anti-depression medication? ☐ Yes ☐ No If yes, please list: _____

_____

What topical medications or creams are you currently using? ☐ Retin A ☐ Others (Please list):

_____

Do you use herbal supplements regularly? ☐ Yes ☐ No If yes, please list: _____

_____

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? (Please mark all that apply)
☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ 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: _____

<u>For our female clients:</u>
Are you pregnant or trying to become pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No
Are you using contraception? ☐ Yes ☐ No

I certify that the preceding medical, medication and personal history statement 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: _____