CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate 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 Address _____City_____State_____

Zip Code _____Phone (_____)_____

Email _____

Emergency Contact Name and Phone_____

How were you referred? _____

May we take before and after photos? Yes_____ No_____

What concerns you most about the overall appearance of your skin? Circle all that apply.

Acne Blackheads Bumps on back of arms Dehydrated Skin
Facial Veins Large Pores Oily Skin Rosacea
Under Eye Puffiness Dark Circles Acne Scarring Body Acne Cellulite Dull Complexion
Fine Lines/Wrinkles Age Spots Melasma Sun Damage Loose Skin Loss of Volume Other

How would you describe your skin? Oily - Dry - Combination - Sensitive
How would you describe your stress level? Little - Moderate - High - Serve
Do you feel your stress level may be affecting the health of your skin? YES or NO
Are you in good health overall? YES or NO What is your daily water consumption in ounces _____
What is your daily consumption of alcohol in ounces_____ Soft drinks_____ Tea/Coffee_____
Do you smoke? YES or NO Do you exercise regularly YES or NO
Do you cleanse your face with HOT WARM COLD water?

Please check the skincare products you are currently using:

_____Cleanser _____Toner _____Serum _____Scrub _____Mask ____Eye Cream _____Moisturizer
_____Sunscreen _____Self Tanner _____Concealer _____Makeup
Brands:_____

Which of the following best describes your skin type? (circle 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 Dark brown skin

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 _____ Last Visit? _____

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

Cancer Diabetes High blood pressure Herpes /Fever blister Arthritis

Frequent cold sores HIV/AID 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, medical conditions or have had any surgeries? Please list: _____
_____

Have you ever had an allergic reaction or have ANY allergies? (List any and all that you have had and describe the reaction you experience) Circle below: _____
Food Animal Protein Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents
Latex Metals Others _____

HISTORY

What oral prescription medications or herbal supplements are you presently taking? _____
_____
Are you on any mood altering or anti-depressant medications?_____
Have you ever used Accutane? Yes _____ No_____ Last use? _____
What topical medications on your skin are you currently using? _____
Have you had Aspirin or Blood thinning products within the last 7days? Yes_____ No_____
Are you taking any anti-inflammatory medications or steroids? Yes_____ No _____
Are you currently using Retin-A Yes_____ No_____
If yes, have you stopped for the last 7 days? Yes_____ No_____
Do you have any metal implants? YES or NO
Have you had any of the following hair removal methods in the past 3 weeks?
Shaving Waxing Electrolysis Tweezing Threading Laser Hair Removal

Do you tan in the sun or in tanning beds? Yes__ No__ Last exposure?_____
Do you have any thick or raised scars from cuts or burns? YES or NO
Do you have problems with healing? (Autoimmune Disease) _____
Are you currently undergoing radiation or chemotherapy? Yes_____ No_____
Do you have a history of skin disease or remarkable skin sensitivities? 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 explain

_____

Have you received Botox in the last 10 days? Yes ____ No ____ Dermal Filler in last 30 days? Yes__ No__
Ethnic/Heritage Background (Parents, Grandparents, & Great Grandparents) _____

_____

FEMALE CLIENTS ONLY

Are you pregnant or trying to become pregnant? Yes _____No_____
Are you breastfeeding? Yes_____ No_____
Are you using contraception? Yes_____ No _____

I have been given pre and post care instructions. (Initial) _____

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 _____

Aesthetician _____ Date _____