



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 \_\_\_\_\_

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 circle one type number)

- 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

**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 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  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 to any of the following? (Please check all that apply and describe the reaction you experienced) Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents Others:\_\_\_\_\_

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### **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): \_\_\_\_\_

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What herbal supplements do you use regularly?\_\_\_\_\_

### **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 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: \_\_\_\_\_

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### **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

*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.*

Signature\_\_\_\_\_ Date:\_\_\_\_\_