



Client Information Medical and Skin Care History

Today's Date ____/____/____

In order to provide you with the most appropriate laser hair removal or skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

Client Name _____ Age _____

Email address _____ Date of Birth ____/____/____

Phone: Home () _____ Cell () _____ Preferred method of contact: _____

Home Address/ City/ State/ Zip _____

Occupation _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Which of the following best describes your skin type? (Please circle only one skin type number)

1. Always burns, never tans
2. Always burns, sometimes tans
3. Sometimes burns, always tans
4. Rarely burns, always tans
5. Brown, moderately pigmented skin
6. Black skin

MEDICAL HISTORY:

Are you currently or within the last year under a physician's care? Yes No

Are you currently being seen by a physician for a medical condition that is not completely diagnosed? Yes No

Do you currently have Health Insurance? 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: _____

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What oral medications are you presently taking? Accutane birth control pills hormones others

(please list): _____

Do you currently have metal implants or a pacemaker? Yes No

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

What topical medications or creams are you currently using? RetinA others: _____

ALLERGIES:

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 cosmetics aspirin lidocaine hydrocortisone hydroquinone or skin bleaching agents others: _____

Reaction: _____

FEMALE CLIENTS:

Are you pregnant or trying to become pregnant? Yes No

Are you currently having or due for your menstrual period? Yes No

Are you using contraception? Yes No

Are you breastfeeding? Yes No

SKIN CARE HISTORY:

Are you currently under the care of a dermatologist? Yes No

Do you wear contact lenses? Yes No

What temperature of water do you usually cleanse with? Hot Warm Cool

Do you have any special skin problems pertaining to your face? Yes No If yes, please specify: _____

Do you have any special skin problems pertaining to your body? Yes No If yes, please specify: _____

Have you ever had a chemical peel? Yes No

Do you experience breakthrough oily shine during the day? Yes No

Do you experience skin breakouts? Yes No

What types of skin care products are you currently using? Soap Toner Mask Cleanser Moisturizer Scrub Peel Other: _____

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Which Skin Care Product lines are you currently using? _____

Have you ever had a spa body treatment? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

When you sunbathe, do you use sunscreen on your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Do you have a tendency to redness? Yes No

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

Do you experience the following skin conditions? Flakiness Tightness Obvious Dryness

Do you have Hyperpigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe _____

MALE CLIENTS:

What is your current shaving system? Wet Electric Other: _____

Have you ever experienced irritations from shaving or experience ingrown hair? Yes No

PERSONAL HABITS:

How many ounces of plain water do you drink daily? _____

How many alcoholic beverages do you drink on average on a weekly basis? 0 1-5 6-8 more than 8

Do you drink caffeinated beverages? Yes No -- If yes, how many daily? _____

Do you smoke? Yes No -- If yes, how many daily? _____

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 as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature: _____ Date: _____

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