



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 INFORMATION

Client Name _____ Today's Date _____
 Date of Birth _____ Occupation _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone () _____ Work Phone () _____
 Emergency Contact Name and Phone _____
 Whom can we thank for referring you to us? _____
 Do you regularly sun bathe or use tanning salons? _____ How often? _____
 When do you plan to be exposed to the sun again? _____
 What type of sun protection do you use? _____
 Do you have any upcoming social events? _____

MEDICAL HISTORY

Are you currently under the care of a physician? 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"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Herpes	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Frequent cold sores	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Keloid scarring	<input type="checkbox"/> Skin disease/Skin lesions	
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hormone imbalance	<input type="checkbox"/> Thyroid imbalance	
<input type="checkbox"/> Blood clotting abnormalities	<input type="checkbox"/> Any active infection			

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

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderate intense heat or infrared irritation? Yes No

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

First day of last menstrual period: _____ Pregnancies _____ Births _____

List any surgeries you have had in the past: _____
 Do you smoke? Yes No If so, how many cigarettes/packs per day? _____

Where does skincare fit into your day? _____

MEDICATIONS

What oral prescription medications are you presently taking? Birth control pills Hormones

Others (It is required that you list all of them): _____
What antibiotics do you use to treat infections? _____
Do you take any medications for heart conditions? _____
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? RetinA Others (Please list): _____

HISTORY

Have you ever had laser hair removal?
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
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: _____

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

SKIN TYPE

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. Rarely burns, always tans
- IV. Rarely burns, always tans
- V. Brown, moderately pigmented skin
- VI. Black skin

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: _____