Client Information and Medical History

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is confidential.

Client Name _____ Date of Birth_____
(Please Print)

Email Address _____

Home Address_____
Street City State Zip

Phone Number (easiest number to reach you) _____

How were you referred to us? _____

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

I. Fair tones - always burns, never tans
II. Light tones - can burn, sometimes tans
III. Medium to olive tones - tans easily
IV. Medium to dark tones
V. Brown tones - moderately pigmented skin
VI. Black skin

Medical History

Are you currently under the care of a physician for any reason? Yes No

If yes, for what _____

History	Yes	No	Date/List/Comments
Accutane			
Antibiotics			
Birth Control Pills			
Hormones			
Aspirin, Ibuprofen use			
Retin A, Tretinoin			
Metro Gel, Metro Cream			
Antidepressants			
Sun Reactions			
Medication Allergies			
Food Allergies			
Aspirin Allergy			
Latex Allergy			
Lidocaine Allergy			
Hydrocortisone Allergy			
Hydroquinone Allergy			
Current Home Skin Care			
Diabetes			
Smoking History			
Cold Sores, Herpes			

History	Yes	No	Date/List/Comments
Bleeding Disorders			
AutoImmune, HIV			
Pregnant (Plan to be) Breastfeeding			
Pacemaker			
Implants of any kind Dental, breast, facial			
Migraine Headaches			
Glaucoma			
Cancer			
Arthritis			
Hepatitis			
Thyroid Imbalance			
Seizure Disorder			
Active Infection			
Radiation in last 3 months			
Skin Conditions			
Acne			
Melasma			
Tattoos, Perm, Makeup, Microblading			
Vitiligo			
Keloid scarring			
Skin/Laser Treatments at another office			If so, when? Results
Botox			If so, when? Results
Fillers			If so, when? Results
Hair Removal			If so, when? Results
Chemical Peels			If so, when? Results
Sun exposure/tanning bed in last week? Self Tanner?			If so, when? Results
List Medical Issues Not Listed Above			

❑ I'm concerned about facial or body hair.
❑ I'm concerned about fine lines around my eyes.
❑ I'm concerned about scowl lines when I frown.
❑ I'm concerned about pigmentation or age spots.
❑ I'm concerned about broken capillaries on my face or spider veins on my legs.
❑ I'm concerned about skin laxity and sagging.
❑ I'm concerned about the lines around my mouth.

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 of my current medical and health conditions and to update this information at subsequent visits. A current history is essential for the provider to execute appropriate treatment procedures. I have signed the consent form for this procedure. I have had the opportunity to ask questions prior to the treatment.

Client Signature _____ **Date**_____