CLIENT 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:

Name:_____ Today's Date_____
Date of Birth:_____ Age:_____ Occupation:_____
Home Address_____ City_____ State_____ Zip_____
Home Phone (__)_____ Cell Phone (____)_____
Email Address_____
Emergency Contact Name:_____ Emergency Contact Phone:_____
How were you referred to us?:_____
Primary Care Physician:_____

ABOUT YOU:

- What is your hereditary background? (circle all that apply) Nordic/ Scandinavian / Irish / English / Asian / Mediterranean / Hispanic / Native American / Middle Eastern / African American / Other _____
- Do you consider your skin (circle the best option): Sensitive / Resilient / Unsure
- Describe your skin (circle all that apply): Normal / Dry / T-Zone / Combination / Thick / Thin / Saggy / Firm / Oily / Acne / Comedones / Blackheads / Milia / Cysts / Breakouts / Acne-Scarred / Large pores / Small pores/ Rosacea / Eczema / Freckled / Sun-damaged / Melasma / Hyperpigmentation / Hypopigmentation / Uneven / Blotchy / Mature / Wrinkled / Patchy dryness / Sallow / Psoriasis / Dehydrated / Lacking moisture / Asphyxiated / Telangiectasia / Broken surface capillaries
- What are the changes you'd most like to see in your skin?
  _____
  _____
  _____

MEDICAL HISTORY:

- Are you currently pregnant or trying to become pregnant? □Yes □ No
- Do you have a history of fainting? □Yes □ No
- Are you currently under the care of a dermatologist? □Yes □No

If yes, please describe _____

- Have you recently had laser resurfacing or facial surgery? ? □Yes □No

If yes, please describe _____
When? _____

- 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)
  □Keloid scarring □Frequent cold sores □Herpes □Lupus □ALS □Myasthenia Gravis □Cancer □Skin disease/Skin lesions □Diabetes □High blood pressure □Arthritis □Heart Disease □Asthma □Stroke □HIV/AIDS □Seizure disorder Hepatitis □Hormone imbalance □Thyroidsease/imbalance □Blood clotting abnormalities □Any active infection- Please specify:_____
  □Psychiatric condition-please specify:_____

Please list any other medical conditions or health problems you have that are not listed above: _____
_____

MEDICATIONS:

- Have you ever used or are you currently using Accutane, Retina-A, Tetinoin, Differin, Tazorac, Avage, Epiduo, Ziana? □Yes □No If yes, decline treatment if any use in last 5 days.
- Are you currently taking any blood thinners? □ Yes □No if yes, please list _____
- Are you on any mood altering or anti-depression medication? □ Yes □No if yes, please list _____
- What medications are you currently taking? (include vitamins, herbal supplements, topicals, patches taken on a daily basis or regular basis.) (Please list):

  _____ _____
  _____ _____
  _____ _____

SOCIAL HISTORY:

- Do you smoke: □ Yes □No If yes, how much:_____
- Do you drink alcohol: □ Yes □No If yes, how frequently:_____
- Do you use any recreational drugs: □ Yes □No If yes please list:_____

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 □Aspirin □Lidocaine □Hydroquinone/skin bleaching agents List all other allergies**:** _____

AESTHETIC HISTORY:

- Have you previously received botulinum toxin injections? □Yes □ No
- If yes, when last done:_____ How many Units:_____
- Have you previously received Filler (hyaluronic acid) injections? □Yes □ No
  If yes, when last done:_____ How many syringes:_____
- Have you ever had medical grade facials? □Yes □No If yes, when last done?_____
  (decline Botox or filler if it has been less than 7 days since last medical peel. Wait 2 weeks to receive a medical facial or medical peel after Botox or filler)
- Have you had any recent tanning bed use or sun exposure that changed the color of your skin in last 2 weeks? □Yes □No *(avoid aesthetic procedures for 2 weeks since skin damage)*
- Do you form thick or raised scars from cuts or burns? □Yes □No *(if yes, avoid use of fillers)*
- Do you have Hyper-pigmentation (darkening of the skin) or Hypo-pigmentation (lightening of the skin) or marks after physical trauma? □Yes □No *(If yes, decline aesthetic procedures)*
- Do you currently use: Facial cleanser □Toner □ Exfoliant □Mask □Night cream other_____
- Have you recently used any self-tanning lotions or treatments? □Yes □No
- 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
- Please list any other aesthetic procedures that you have undergone:_____
- Please list any additional aesthetic procedures that you would like to receive or have available to you:_____

For female clients:

- Are you pregnant or trying to become pregnant? □Yes □No
- Are you breastfeeding? □Yes □No
- Are you using contraception? □Yes □No

I understand that a current medical history is essential for the caregiver to execute appropriate treatment procedures and provide the best care for me. I certify that the above medical, personal and aesthetic history statements are true and complete. 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 I agree to update this history as necessary.

Signature:_____ Date:_____