Confidential Client Health History Form

 Date:

Name: Date of Birth: Age:

Address:

 Street City State Zip

Home Phone: Cell Phone:

E-mail:

Physician: Phone:

Emergency Contact: Phone:

Employer: Occupation:

Does your job require that you work outdoors? ⃝No ⃝Yes

Referred by:

# Your Health

1. Have you been under the care of a physician, dermatologist or other medical professional within the past year?

⃝No ⃝ Yes, explain:

1. Any recent surgery, including plastic surgery? ⃝No ⃝Yes, explain:
2. Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided)

Cancer o

Hormone imbalance o

Systemic disease o

High blood pressure o

Spinal injury o

Thyroid condition o

Hysterectomy o

Diabetes o

Heart problem o

Varicose veins o

Arthritis o

Asthma o

Eczema o

Epilepsy o

Seizure disorder o

Fever blisters o

Headaches (chronic) o

Hepatitis o

Herpes o

Frequent cold sores o

Immune disorders o

HIV/AIDS o

Lupus o

Metal bone pins or plates o

Phlebitis, blood clots, poor circulation o

Blood clotting abnormalities o

Psychological treatment o

Insomnia o

Keloid scarring o

Skin disease/skin lesions o

Any active infection o

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Health History Continued…

1. Do you smoke? ⃝ No ⃝ Yes
2. Do you follow a restricted diet? ⃝ No ⃝ Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you go tanning? ⃝No ⃝ Yes, how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you follow a regular exercise program? ⃝ No ⃝ Yes
5. What is your stress level? High ⃝ Medium ⃝ Low ⃝
6. List any medications you take regularly (including prescription medications and over the counter):

1. List your daily consumption of: Water Caffeine Alcohol\_\_\_\_\_\_\_\_\_
2. How many hours do you typically sleep each night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you have any metal implants or wear a pacemaker? ⃝ No ⃝ Yes
4. Have you ever experienced claustrophobia? ⃝ No ⃝ Yes
5. Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

 Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

# Female Clients Only:

1. Are you taking oral contraceptives? ⃝ No ⃝ Yes, specify:
2. Any recent changes to or from your contraceptive treatment? ⃝ No ⃝ Yes, If so, what and when?
3. Are you pregnant or trying to become pregnant? ⃝ No ⃝ Yes
4. Are you lactating? ⃝ No ⃝ Yes
5. Any menopause problems? ⃝ No ⃝ Yes, specify:

 Skin Care

1. Have you ever had a facial treatment before? ⃝ No ⃝ Yes, when?
2. What would you like to achieve from your treatment today?

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

|  |  |  |
| --- | --- | --- |
| I | Creamy complexion | Always burns easily, never tans |
| II | Light Complexion | Always burns, tans slightly |
| III | Light/Matte Complexion | Burns moderately, tans gradually |
| IV | Matte Complexion | Seldom burns, always tans well |
| V | Brown Complexion | Rarely burns, deep tan |
| VI | Black Complexion | Never burns, deeply pigmented |

1. Do you have any special skin problems or concerns pertaining to your face or body? ⃝ Yes ⃝ No

Specify

1. How would you describe your skin: (please circle all that apply)

Dry Dehydrated Oily Acne-prone Sensitive Combination

1. Have you ever had chemical peels, laser or microdermabrasion? ⃝ No ⃝ Yes, in the last month? ⃝ No ⃝ Yes
2. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? ⃝ No ⃝Yes
3. Have you used any of these products in the last 3 months? ⃝ No ⃝ Yes
4. Have you used an acne medication? ⃝ No ⃝Yes, name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you used any of the following hair removal methods in the past six weeks? ⃝ No ⃝ Yes, circle all that apply.

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

1. What areas of concern do you have regarding your: **Skin:** (Please check any that apply and explain)

Breakouts/acne o

Blackheads/whiteheads o

Excessive oil/shine o

Rosacea o

Broken capillaries o

Redness/ruddiness o

Sun spot/liver spot/brown spot o

Uneven skin tone o

Sun damage o

Wrinkles/fine lines o

Dull/dry skin o

Flaky skin o

Dehydrated o

Other

1. What skin care products are you currently using? (please fill brand name in blank)

Cleanser \_\_\_\_\_\_\_\_\_\_\_\_\_\_Toner \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Serum \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Moisturizer \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Cream \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scrub/Mask \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPF \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_

Confidential Client Medical History Disclosure Consent

**Please Sign and Date:**

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: Date: