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 HISTORY

Client Name: ____ Date: _________________________

Date of Birth : _______________________ Age: _____________ Occupation: _______________________

Home Address: ____

City: _____________________________ State: ________________ Zip Code:_________________________

Home Phone: ________________________ Mobile Phone: _____________________ Text OK: Yes No

Emergency Contact Name and Phone: ____

How were you referred to me? ____

Do you regularly sun bathe or use tanning salons? Yes No How often?____________________________

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)

- O Cancer
- O Diabetes
- O High blood pressure
- O Herpes
- O Arthritis
- O Frequent cold sores
- O HIV/AIDS
- O Keloid scarring
- O Skin disease /Skin lesions
- O Seizure disorder
- O Hepatitis
- O Hormone imbalance
- O Thyroid imbalance
- O Blood clotting abnormalities
- O Any active infection

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

____

Have you ever had an allergic reaction?
(List any and all that you have had and describe the reaction you experienced)

O Food O Animal Protein O Aspirin O Lidocaine O Hydro Cortisone

O Hydroquinone or skin bleaching agents O Others: ____

MEDICATIONS

What oral prescription medications are you presently taking?

O Birth control pills O Hormones O Others (It is required that you list all of them):

____

What antibiotics do you use to treat infections? ____

Do you take any medications for other chronic health conditions? ____

Are you on any mood altering or anti-depression medication? ____

What topical medications or creams are you currently using? O RetinA O Others (Please list):

____

What herbal supplements do you take regularly? ____

FOR OUR FEMALE CLIENTS:

Are you pregnant or trying to become pregnant? Yes No

Are you breast feeding? Yes No

Are you using contraception? Yes No

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: _______________________________