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____ Today's Date ________________

Date of Birth__________Age__________Occupation____

Home Address_________________________ City______________________ State___Zip Code_____

Home Phone ( ) Work Phone (____)__________ _________________________

Emergency Contact Name and Phone ____

How were you referred to us? ____

Do you regularly sun bathe or use tanning salons? 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)

☐Cancer ☐Diabetes ☐High blood pressure ☐Herpes ☐Arthritis

☐ Frequent cold sores ☐HIV/AIDS ☐Keloid scarring ☐Skin disease/Skin lesions

☐ Sleep disorder ☐Hepatitis ☐Hormone imbalance ☐Thyroid imbalance

☐ Blood clotting abnormalities ☐ 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)

☐Food ☐Animal Protein ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Hydroquinone or skin bleaching agents ☐Others:

____

____

____

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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? _________________________________

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

____

What herbal supplements do you use regularly? ____

HISTORY

<u>For our female clients:</u>

Are you pregnant or trying to become pregnant? ☐Yes ☐No Are you breastfeeding? ☐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:________________