CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser 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____

Cell Phone (___)_____ Email Address _____

Emergency Contact Name and Phone_____

How were you referred to us? _____

Which of the following best describes your skin type?

Circle one:	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

How would you describe your skin?

__ Oily/Congested
__ Dry/Dehydrated
__ Sensitive/Redness
__ Acne prone
__ Sunburned

MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑ No

If yes, for what:_____

_____

Are you currently under the care of a dermatologist? ❑Yes ❑No

If yes, for what:_____

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)

❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis

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

❑Seizure disorder ❑Hepatitis ❑Hormone imbalance ❑Thyroid imbalance

❑Blood clotting abnormalities ❑Any active infection

❑Metal implants, soft implants, pacemaker or body piercings

__ Eczema __ Acne __ Rosacea __ Claustrophobia __ Shingles __ Headaches

Any other medical conditions? Please list: _____

Would you like to receive promotional & event information from Shea Aesthetic Clinic? __Yes __No

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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 ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others:_____

Any big events or vacations planned in the next 6 months? _____

MEDICATIONS

What oral medications are you presently taking? ❑Birth control pills ❑Hormones
❑Others (Please list): _____

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

Have you ever used Accutane? ❑Yes ❑No, If yes, when did you last use it? _____

What topical medications or creams are you currently using? ❑ Retin-A® ❑ Renova or Adapalene

Others (Please list): _____

What herbal supplements do you use regularly?_____

HISTORY

Have you ever had laser hair removal? ❑Yes ❑No

Have you used any of the following hair removal methods in the past six weeks?

❑Shaving ❑Waxing ❑Electrolysis ❑Plucking ❑Tweezing ❑Stringing ❑Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ❑Yes ❑No

Have you recently used any self-tanning lotions or treatments? ❑Yes ❑No

Do you form thick or raised scars from cuts or burns? ❑Yes ❑No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑Yes ❑No If yes, please describe: _____

_____

Have you had surgery in the last year (if yes, please specify)_____

Have you recently had: chemical peel, microdermabrasion, Botox, laser treatment, tanning, spray tan? If so, specify when: _____

For our female clients:

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, personal and skin history statements are true and correct. 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 to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____

Shea
AESTHETIC CLINIC

Consent to Receive Service

I, _____ agree that this is my right to receive services from Shea Aesthetic Clinic. I have completed this form to the best of my knowledge, and have stated all medical conditions that I am aware of. I know that it will be my responsibility to inform the staff at Shea Aesthetic Clinic of any and all changes in my medical history, and changes in my current health status.

I agree that if I am unable to make my appointment, I will notify the staff at Shea Aesthetic Clinic within 24 hours of my scheduled appointment. In event of an emergency, I will call right away and cancel. I do understand that charges may occur after the 1st late cancelation. If I miss a scheduled appointment without notice I will agree to pay the missed appointment fee that will be applied.

I am signing below to state that I understand all the above information.

Name_____

Date_____

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