Client Health History

Last Name:______________________ First Name: ______________________ DOB:__________ Sex: F / M

Address:______________________________ City:______________ State:_____ ZIP:________

Phone: (Cell) ______________________ (Home) ______________________ Ok to leave messages? Y/N

E-mail Address: ______________________________________ Join Email List for Specials? Y/N

Your e-mail address is used for 1-3 promotional e-mails a month and will never be shared or sold.

How would you like to receive appointment reminders? ☐ Phone Call ☐ Text Message ☐ Email ☐ None*

**Please note that failure to keep your appointment or cancel within 24 hours may result in additional fees. See Policies for details.*

Current Occupation/ Employer: ______________________________________

How did you hear about us? ☐ Google ☐ Yelp ☐ Newspaper Ad ☐ Social Media ☐ Sign

☐ From a friend, please provide his/her name so we can thank them: ______________________

Which treatments are you interested in? (Please check all that apply)

- ☐ SculpSure- Body Contouring
- ☐ Laser Hair Removal
- ☐ Intense Pulsed Light (IPL)
- ☐ Pixel Laser Skin Resurfacing
- ☐ Sclerotherapy
- ☐ Botox
- ☐ Dermal Fillers
- ☐ Kybella
- ☐ Micro Needling
- ☐ PRP (Platelet Rich Plasma)
- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Facials (treatment or relaxing)
- ☐ Skin Care Products
- ☐ Other: ______________

Have you ever had any of the above treatments in the past? Yes / No Date of last treatment(s): __________

Health & Medical Information

Please list **all** medications (prescription or over-the-counter), any herbals or supplements that you are currently taking, or have taken in the last year, including acne medications (Accutane, Retin-A, Tretinoin or Renova). This includes topical meds used in the treatment area.

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Please list **all** allergies and sensitivities:

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Please check the box(es) next to any health condition below that applies to you now or in the past:

- ☐ Allergic Dermatitis
- ☐ Anxiety/Panic Attack
- ☐ Asthma
- ☐ Auto Immune Disorder
- ☐ Bleeding Disorders/Blood Clots
- ☐ Blood Clots
- ☐ Cancer / Skin Cancer
- ☐ Cardiac Problems/ Heart Attack
- ☐ Compromised Healing Response
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Dizzy Spells
- ☐ Gold / Silver Therapy
- ☐ Headaches / Migraines
- ☐ Heat Urticaria
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes / Cold Sores / Fever Blisters
- ☐ Hormone Imbalance
- ☐ Hirsutism
- ☐ High Blood Pressure
- ☐ Hyperhidrosis / Excessive Sweating
- ☐ Immune Compromising Illness or Disease
- ☐ Infectious Skin Conditions
- ☐ Jaw Pain
- ☐ Keloid Formation (thick, raised scars)
- ☐ Neck Pain
- ☐ Pacemaker
- ☐ PMS
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Post-Traumatic Stress Disorder
- ☐ Pregnancy/Lactating Currently
- ☐ Psoriasis / Exzema / Vitiligo / Melasma
- ☐ Radiation Therapy
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Photosensitivity
- ☐ Skin Disorders affecting collagen- Ehlers-Danlos Syndrome, Scleroderma
- ☐ Stroke
- ☐ Thyroid Disorder

Other Conditions:

(Continued on back)

Please describe any checked health condition(s) from previous page:

____

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Other notable health conditions not listed: ______________________________

In the event of an emergency, who should we contact?

Name:____________________ Phone: ____________________ Relation: ______________

Skin Condition & Lifestyle Information

Do you wear a broad spectrum sunscreen of SPF 30+? Yes / Sometimes / No

Do you spend a lot of time in the sun/outdoors? Yes / Sometimes / No

Do you use a tanning bed or tan in the sun? Yes / Sometimes / No Last time tanning:____________

Do you use a self tanner or spray tanning? Yes / Sometimes / No

Do you blush or turn red easily? Yes / Sometimes / No

Do you have sensitivity to products? Yes / Sometimes / No

Do you have, or have you recently had sunburn? Yes / No Describe: ____________________

Have you ever had a cosmetic surgery or procedure? Yes / No Describe: ____________________

Do you have any tattoos or permanent makeup? Yes / No Describe: ____________________

Do you have problems with getting your blood drawn? Yes / No Describe: ____________________

Please list all skin care products used, including brand:

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Do you use glycolic acid, alpha-hydroxy acids or beta-hydroxy acids, resurfacing or exfoliating products? Yes / No

What is your typical daily intake of the following?

Water	☐ None	☐ Light	☐ Moderate	☐ Heavy
Caffeine	☐ None	☐ Light	☐ Moderate	☐ Heavy
Salt	☐ None	☐ Light	☐ Moderate	☐ Heavy
Sugar	☐ None	☐ Light	☐ Moderate	☐ Heavy
Cigarettes	☐ None	☐ Light	☐ Moderate	☐ Heavy
Dairy	☐ None	☐ Light	☐ Moderate	☐ Heavy

Do you have concerns with any of the following conditions? (Please check all that apply)

- ☐ Acne
- ☐ Age/Brown Spots
- ☐ Fine Lines/Wrinkles
- ☐ Major Lines/Wrinkles
- ☐ Rosacea
- ☐ Uneven Skin Tone
- ☐ Uneven Skin Texture
- ☐ Sagging Skin
- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Unwanted Scars
- ☐ Unwanted Hair
- ☐ Spider Veins
- ☐ Cherry Angiomas
- ☐ Unwanted / Stubborn fat
- ☐ Other: ____________________

By providing my signature below, I confirm that the information recorded above is complete and accurate to the best of my knowledge. I am in good physical condition and mental state. I have no physical restrictions, conditions, disabilities or ailments that are not noted above.

Client Signature: ______________________________ Date: ____________________

☐Check here if you are signing as the parent or legal guardian for a minor under the age 18.

Office Use Only

Reviewed By: ______________________________ Date: ______________ Client ID: ______________