UNIQUE TO YOU Confidential Client Health History Form

Date: _____ Name: _____

Emergency Contact: _____ Phone: _____

Please circle appropriate answers:

1) List any medical conditions: _____
Name of Physician _____ Phone _____
Name of Dermatologist _____ Phone _____

2) Any recent surgery, including plastic surgery? No Yes, explain: _____

3) Any skin cancer? No Yes, explain: _____

4) 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	_____Hormone imbalance	_____Systemic disease
_____High blood pressure	_____Spinal injury	_____Thyroid condition
_____Hysterectomy	_____Diabetes	_____Heart problem
_____Varicose veins	_____Arthritis	_____Asthma
_____Eczema	_____Epilepsy	_____Seizure disorder
_____Fibromyaliga	_____Headaches (chronic)	_____Hepatitis
_____Herpes	_____Frequent cold sores	_____Thyroid Conditions
_____Autoimmune disorders	_____HIV/Aids	_____Lupus
_____Skin diseases/lesions	_____Any active infection	_____Other _____

_____Phlebitis, blood clots, poor circulation, blood clotting abnormalities

Current prescription medications are taken for: _____
_____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:
_____

5) Do you smoke? No Yes
6) Do you form thick or raised scars from cuts or burns? No Yes
7) Do you wear contact lenses? No Yes
8) Have you been exposed to the sun or used a tanning bed in the last 48 hours? No Yes
9) Do you have any metal implants or wear a pacemaker? No Yes
10) Have you ever experienced claustrophobia? No Yes

Please use this space to complete answers where space was insufficient. (Please include the number of the question)
_____
_____
_____

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 of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____