Confidential and General Medical History

Name_____**DOB**_____**Age**_____
Address_____**City**_____**St**_____**Zip**_____
Home#_____**Cell#**_____**Email**_____

Doctors Names	**Current Medications**
Medication Allergies	
Food Allergies	
Previous Surgeries and Dates	
	Female Client Medical History
	In menopause yes no
	Post menopause yes no
	Regular periods yes no
	Hormone Imbalance yes no
	Pregnant yes no
	Are you taking any of the following?
	_____Birth Control _____ Hormones

Do you have any of the following?

Acne	y / n	Autoimmune disorder	y / n
Thyroid	y / n	Cancer	y / n
Cold sores	y / n	Contact Lenses	y / n
Dermatitis	y / n	Diabetes	y / n
Herpes	y / n	Latex Allergy	y / n
Tattoos	y / n	Shingles	y / n
Dry Eyes	y / n	Tan	y / n
Hearing Aid	y / n	Heart Condition	y / n
Hemophilia	y / n	Hepatitis	y / n
HIV	y / n	Keloid Scar	y / n
Metal in Body	y / n	Hyperpigment	y / n
Pacemaker	y / n	Bleeding Disorder	y / n
Moles	y / n	Problems healing	y / n

Rate your skin type based on the following scale:

___Type I Always burns, never tans.
___Type II Usually burns, tan less than average.
___ Type III Sometimes mild burn, tan about average
___ Type IV Rarely burns, tan more than average.

Have you used or have you had any of the following?

Accutane	Laser Resurfacing	Liposuction
Retin A	Photo Derm	Pulsed Dye Laser
Chemical Peel	IPL	Skin Grafts
Glycolic Acid	Sunburn	Injectibles
Botox	Filler	Smoke

O**n what areas have you had treatments for hair removal?**

_____

I acknowledge that all the above information is true and accurate to the best of my knowledge.

Signature_____ **Date**_____