SKINSPIRE
ESTHETICS

Today's Date:_____

Client Medical History

In order to provide you with the most appropriate treatment plan, please complete the following questionnaire. All information is strictly confidential

CONTACT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell ❑ Work ❑ Home ❑ Occupation: _____

Email Address: _____

Emergency Contact Name: _____ Phone: _____

How were you referred to us? _____

MEDICAL HISTORY

1. Which of the following best describes your skin type?

❑ Always Burns, Never Tans
❑ Always Burns, Sometimes Tans
❑ Sometimes Burns, Always Tans
❑ Rarely Burns, Always Tans
❑ Brown, Moderately Pigmented Skin
❑ Black Skin

2. Are you exposed to sun on a daily basis or are you considering spending more time in the sun soon? Yes ❑ No ❑

3. Do you have a history of livido reticularis, an autoimmune disease, in which the blood vessels are constricted, or narrowed resulting in mottled discoloration on large areas of the arms or legs? Yes ❑ No ❑

4. 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 irradiation? Yes ❑ No ❑

5. Do you have any of the following medical conditions? (Check all that apply)

❑ Arthritis
❑ Blood Clotting
❑ Cancer
❑ Diabetes
❑ Frequent Cold Sores
❑ Hepatitis
❑ Herpes
❑ High Blood Pressure
❑ HIV / AIDS
❑ Hormone Imbalance
❑ Keloid Scaring
❑ Seizure Disorder
❑ Skin Disease
❑ Skin Lesions
❑ Thyroid Imbalance
❑ Any Active Infection

6. Do have any other health problems or medical conditions? Yes ❑ No ❑ If YES, Please list below

_____

7. Are you currently taking any oral medications? Yes ❑ No ❑ If YES, Please list below

_____

8. Are you currently using any topical creams or medications? Yes ❑ No ❑ If YES, Please list below

_____

9. Are you currently under the care of a physician? Yes ❑ No ❑ If YES, What for and how long?

_____

10. Are you currently under the care of a dermatologist? Yes ❑ No ❑ If YES, What for and how long?

_____

Client's Name _____

11. Do you use a tanning be or go to a tanning salon Yes ❑ No ❑ If YES, when? _____
12. Have you ever used or currently taking Accutane? Yes ❑ No ❑ If YES, when? _____
13. Have you ever used or currently taking Retin-a or Renova? Yes ❑ No ❑ If YES, when? _____
14. Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 48-72 hours? Yes ❑ No ❑ If YES, when? _____
15. Are you using other skin thinning drugs or products drugs? Yes ❑ No ❑ If YES, what & when?

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16. Have you ever had laser hair removal? Yes ❑ No ❑
17. Have you used any of the following hair removal methods in the past six weeks? Yes ❑ No ❑

❑ Depilatories ❑ Shaving ❑ Waxing
❑ Electrolysis ❑ Stringing ❑ Other: _____
❑ Plucking ❑ Tweezing

18. Have you recently used any self-tanning lotions or treatments? Yes ❑ No ❑
19. Do you form thick or raised scars from cuts or burns? Yes ❑ No ❑
20. Do you have hyperpigmentation (darkening) or hypopigmentation (lightening) of the skin or marks after physical trauma? Yes ❑ No ❑

For our Female clients:

Are you currently pregnant or trying to become pregnant? Yes ❑ No ❑ 21. Are you breastfeeding? Yes ❑ No ❑

22. Are you using contraception? Yes ❑ No ❑ 23. When was your last menstrual cycle? _____

(Always allow 5 days for menstrual cycle. Due to water retention and personal comfort, hair removal should be avoided 2 days before and 2 days after your cycle.)

ALLERGIES

24. Have you ever had an allergic reaction to any of the following? (Check all that apply)

❑ Aspirin ❑ Lidocaine ❑ Hydroquinone
❑ Cosmetics ❑ Hydrocortisone ❑ Skin Bleaching Agents
❑ Food ❑ Latex ❑ Others: _____

I warrant that I am 18 years of age or older and that I am competent to contract in my own name. 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/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

❑ *If the client is under the age of 18, then this health history and consent must be signed by a parent or guardian, as follows:*
I hereby certify that I am the parent or guardian of the client named above, and do hereby give my consent without reservation to the forgoing on behalf of this individual.

Print Name	**Client Signature**	**Date**
Print Name	**Guardian Signature**	**Date**