# Health History

Date: _____

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Date Of Birth: _____

Your Heath:

Have you been under the care of a physician, dermatologist or other medical professional within the past year?
Yes_____No_____

Explain:_____

Any recent surgery, including plastic surgery? Yes_____No_____

Explain: _____

Any cancer skin or other? Yes_____No_____

Explain: _____

Have you had any piercings, tattoos, or permanent cosmetics? Yes_____No_____

If yes, any problums & what: _____

_____

Do you smoke? Yes_____No_____

Do you follow a restricted diet? Yes_____No_____, Specify: _____

_____

Do you follow a regular exercise program? Yes_____No_____

List your daily consumption of: Water:_____Caffeine:_____Alcohol:_____

Do you experience any problems sleeping? Yes_____No_____

How many hours do you typically sleep each night? _____

Have you ever experienced claustrophobia? Yes_____No_____

Do you suffer from sinus problems? Yes_____No____

What is your stress level? High_____Medium_____Low_____

Do you wear contact lenses? Yes_____No_____

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 | | Headaches (chronic) | | Hepatitis | |
| Frequent Cold Sores | | Immune Disorders | | HIV/AIDS | |
| Any Active Infection | | Insomnia | | Keloid Scarring | |
| Thyroid Condition | | Hormone Imbalance | | High Blood Pressure | |
| Varicose Veins | | Hysterectomy | | Diabetes | |
| Epilepsy Seizure Disorder | | Arthritis | | Asthma | |
| Metal Bone Pins or Plates | | Fever Blisters | | Phlebitis or Poor Circulation | |
| Skin Disease/Skin Lesions | | Spinal Injury | | Heart Problem | |

_____

_____

List any medications you take regularly:

_____

_____

Do you suffer from back pain or disk herniation? Yes_____No_____

Do you have cardiac or circulatory problems? Yes_____No_____

Do you suffer from joint swelling? Yes_____No_____

Do you have varicose veins? Yes_____No_____

Do you have osteoporosis? Yes_____No_____

Have you ever had an allergic reaction? Yes_____No_____

If yes please explain:

_____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin "A" derivative products? Yes_____No_____, describe: _____

Have you used any of these products in the last 3 months? Yes_____No_____

Do you form thick or raised scars from cuts or burns? Yes_____No_____

Do you have Hyperpigmentation (darkening of the skin) or Hypo pigmentation (lightening of the skin) or marks after physical trauma? Yes_____No_____, Describe: _____

Do you bruise easily? Yes_____No_____

How frequently are you exposed to the sun or use a tanning bed?

Infrequently_____ Frequently_____ Regularly_____

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

Other medical condition I should know about? _____

_____

Female Clients Only:

Are you pregnant? Yes_____No_____

Are you taking oral contraceptives? Yes_____No_____ Specify:_____

Are you undergoing any hormone replacement therapy? Yes_____No_____

Specify: _____

Any recent changes to or from your contraceptive treatment? Yes_____No_____

If so, what and when?_____

Are you pregnant or trying to become pregnant? Yes_____No_____

Are you lactating? Yes_____No_____

Any menopause problems? Yes_____No_____ Specify: _____

Please use this space to complete answers where space was insufficient.

_____

_____

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. I am aware that it is my responsibility to inform the therapist/esthetician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this office and/or skin care professional from liability and assume full responsibility thereof.

Date: _____

Name (Please Print): _____

Client Signature:_____