Confidential Client Health History Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?
m No □ Yes, explain: _____

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

_____

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

4) Have you had any piercings, tattoos, or permanent cosmetics? □ No □ Yes, If yes, where on your person?

_____

_____

5) Have you ever had a body spa treatment before? □ No □ Yes, when: _____

6) 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)	□
Hormone imbalance	□	Hepatitis	□
Systemic disease	□	Herpes	□
High blood pressure	□	Frequent cold sores	□
Spinal injury	□	Immune disorders	□
Thyroid condition	□	HIV/AIDS	□
Hysterectomy	□	Lupus	□
Diabetes	□	Metal bone pins or plates	□
Heart problem	□	Phlebitis, blood clots, poor circulation	□
Varicose veins	□	Blood clotting abnormalities	□
Arthritis	□	Psychological treatment	□
Asthma	□	Insomnia	□
Eczema	□	Keloid scarring	□
Epilepsy	□	Skin disease/skin lesions	□
Seizure disorder	□	Any active infection	□
Fever blisters	□		

7) Has your physician discussed concerns about raising your body temperature? □ No □ Yes
Please explain: _____

8) Do you smoke? □ No □ Yes

List any medications you take regularly: _____

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

9) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products? □ No □ Yes, describe: _____

10) Have you used any of these products in the last 3 months? □ No □ Yes

11) Have you used an acne medication? □ No □ Yes, when? _____ Which drug? _____

12) Do you form thick or raised scars from cuts or burns? □ No □ Yes

13) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? □ No □ Yes, describe: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

14) Do you experience any problems sleeping? □ No □ Yes

15) How many hours do you typically sleep each night? _____

16) Do you wear contact lenses? □ No □ Yes

17) Have you been exposed to the sun or used a tanning bed in the last 48 hours? □ No □ Yes

18) How frequently are you exposed to the sun or use a tanning bed? ___ Infrequently ___ Frequently ___ Regularly

19) Do you have any metal implants or wear a pacemaker? □ No □ Yes

20) Have you ever experienced claustrophobia? □ No □ Yes

21) Do you suffer from sinus problems? □ No □ Yes

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

Rash Irritation Peeling Sun Sensitivity Breakout

23) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics **Medicines** Food Animals Sunscreens Iodine Pollen AHAs

Fragrance Shellfish Latex Drugs Other: _____

If yes, please explain: _____

Female Clients Only:

24) Are you taking oral contraceptives? □ No □ Yes, specify: _____

25) Any recent changes to or from your contraceptive treatment? □ No □ Yes, If so, what and when? _____

_____

_____

26) Are you pregnant or trying to become pregnant? □ No □ Yes

27) Are you lactating? □ No □ Yes

28) Any menopause problems? □ No □ Yes, specify: _____

Please use this space to add any information you would like us to know:

_____

_____

_____

_____

_____

_____

How did you hear about us? _____

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 A Little Skin Studio LLC and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____