Client Medical History

Personal History

Name:

Email:

Date Of Birth: _____ Age:

Occupation:

Home Address:

City:_____ State:

Phone Number:

Emergency Contact Name and number

Which of the following best describes your skin type? (Please circle one)

I: Always burns, never tans

II: Always burns, sometimes tans

III: Sometimes burns, sometimes tans

IV: Rarely burns, always tans

V: Brown, moderately pigmented skin

VI: Black skin

Do you regularly use a tanning salon or sun bathe?

☐ Yes

☐ No

If Yes, how Often:

Medical History

Name of preferred pharmacy:

Are you currently under the care of a physician?

- ☐ Yes
- ☐ No

If Yes, please explain:

Are you currently under the care of a dermatologist?

- ☐ Yes
- ☐ No

If Yes, please explain:

Do you have any of the following medical conditions? (Please circle all that apply)

Cancer	Herpes	HIV/AIDS	Seizure Disorder
Diabetes	Arthritis	Keloid Scarring	Hepatitis
High Blood Pressure	Frequent Cold Sore	Skin Disease/Skin Lesion	Hormone Imbalance
Thyroid Imbalance	Blood Clotting Abnormalities	Any Active Infection	
Liver Disease	Kidney Disease	Heart Attack	Stroke
COPD	Asthma	Shingles	Ellers Danlos
Melasma	Prone to infection	On Blood Thinners	Neuromuscular Disorders
Congestive Heart Failure	Electrolyte Imbalance	G6 PD Deficiency	

Do you have any other health problems or medical conditions? Please list:

Do you use any tobacco products? (cigarettes, chewing tobacco, vape)

- ☐ Yes
- ☐ No

If yes how often?

Have you ever had allergic reaction to the following? (Please select all that apply and describe the reaction)

- ☐ Food
- ☐ Latex
- ☐ Asprin
- ☐ Lidocaine
- ☐ Hydrocortisone
- ☐ Hydroquinone or skin bleaching agents
- ☐ Sulfa
- ☐ Bees or wasps
- ☐ None

Any other allergies not listed above?

Medications

What oral medications/supplements are you currently taking?

Have you ever used Acutane?

- ☐ Yes
- ☐ No

If yes, when did you last take it?

What topical medications or creams are you currently using?

Vaccinations within the last 4 weeks?

- ☐ Yes
- ☐ No

If yes, what?

For Female Clients

Are you currently pregnant or trying to become pregnant?

- ☐ Yes
- ☐ No

Date of last menstrual cycle?

Date of last pap?

Pap results:

History of abnormal pap?

Are you breastfeeding?

- ☐ Yes
- ☐ No

I certify that the preceding medical,personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropraite treatment procedures.

Client Signature:_____ Date: