Confidential Client Health History Form

Date: ____________________

Name: ____ DOB: ________________

Address: ____ City: __________________ Zip: ________

Home Phone: _______________________________________ Cell Phone: _____________________

Email Address: ____

Physician: ____ Phone: _________________________

Emergency Contact: __________________________________ Phone: _________________________

Approval to contact you? □ No □ Yes Referred by: ____

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

2) Have you had any surgeries, including plastic surgery? □ No □ Yes, explain: ______________
____

3) Have you ever had □ Botox, □ fillers, or □ facial lasers? If so, when? ____________________

4) List any medications (including prescription skin care products, acne medication, birth control, etc.) you take regularly: ____

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

6) List any known drug allergies: ____

7) Have you ever 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 ___________(type) □
Hormone imbalance □
High blood pressure □
Spinal injury □
Thyroid condition □
Thyroid condition □
Diabetes □
Heart problem □
Arthritis □
Asthma/Breathing problems □
Keloid scarring □
Seizure disorder □

Headaches (chronic) □
Hepatitis □
Fever blisters/Cold sores □
Immune disorders □
HIV/AIDS □
Metal bone pins or plates □
Blood clotting abnormalities □
Psychological treatment □
Skin diseases/skin cancer _________(type) □
Any active infection □
Any eye problems □

8) Do you smoke? ☐ No ☐ Yes

9) Do you drink alcohol? ☐ No ☐ Yes If yes, how much do you drink? _______/day _______/week

10) Have you ever had an allergic reaction to any of the following?
(Please check all that apply and provide additional information in the space provided)

Cosmetics	☐	Medicine	☐
Skin Care Products	☐	Latex	☐
Fragrance	☐	Iodine	☐
Sunscreens	☐	AHAs (alpha-hydroxy acids)	☐
Food	☐	Drugs	☐
Shellfish	☐	Pollen	☐
Animals	☐		

Other: ______________________________

If yes, please explain: ______________________________

11) Do you form thick or raised scars from cuts or burns? ☐ No ☐ Yes

12) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ No ☐ Yes, describe: ______________________________

13) How often are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___ Regularly

14) What SPF do you use on your face? ______________ How often/when? ______________

15) Have you recently used any self-tanning lotions, creams or treatments? ☐ No ☐ Yes, specify: __________

16) Have you used any of the following hair removal methods in the past six weeks? ☐ No ☐ Yes

Shaving	☐	Electrolysis	☐
Waxing	☐	Stringing	☐
Plucking	☐	Depilatories	☐
Tweezing	☐		

17) Have you ever had a body spa treatment before? ☐ No ☐ Yes, when: ______________________________

18) What skin care products are you currently using? (List brand where known)

Soap ______________	Shower Gels ______________
Toner ______________	Body Lotions ______________
Mask ______________	Sunscreen ______________
Eye Product ______________	Night Moisturizer/Cream ______________
Cleanser ______________	Day Moisturizer ______________
Exfoliator ______________	Scrubs ______________

Makeup Products ______________________________

Other ______________________________

19) What areas of concern do you have regarding your: (Please check any that apply)

Skin:

Breakouts/acne	□	Uneven skin tone	□
Blackheads/whiteheads	□	Sun damage	□
Excessive oil/shine	□	Wrinkles/fine lines	□
Rosacea	□	Dull/dry skin	□
Broken capillaries/redness	□	Flaky skin	□
Sun spot/liver spot/brown spot	□	Dehydrated	□
Thin eyelashes	□		

Eyes:

Dehydrated □ Wrinkles □ Puffiness □ Dark circles □ None □

Other: ____________________

Lips:

Dehydrated □ Cracked/chapped lips □ None □ Other: ____________________

20) I would like to know more about:

Please check all that apply:

□ Eyelash length, fullness, thickness, or darkness	□ Facial veins
□ BOTOX® Cosmetic/Dysport for wrinkles	□ Facial redness
□ Facial Fillers (Restylane, Juvederm, Perlane, Radiesse)	□ Liver spots/age spots
□ Cosmetic Eyelid surgery	□ Birthmark
□ Laser Skin Resurfacing or other treatments	□ Blotchy skin
□ Skin care products/advice	□ Drooping eyelids
□ Thin lips	□ ____________

Female Clients Only:

21) Are you taking oral contraceptives? □ No □ Yes, specify: ____________________

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

23) Are you breast feeding? □ No □ Yes

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 aesthetician/doctor 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.

____________________ ____________

Client Signature Date