



CONFIDENTIAL CLIENT HEALTH HISTORY FORM

Date: _____

Name: _____ Date Of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Business Phone: _____

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?

No Yes, explain: _____

2) Any recent surgery, including clastic 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 | <input type="checkbox"/> | Headaches (chronic) | <input type="checkbox"/> |
| Hormone imbalance | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| Systemic disease | <input type="checkbox"/> | Herpes | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | Frequent cold sores | <input type="checkbox"/> |
| Spinal injury | <input type="checkbox"/> | Immune disorders | <input type="checkbox"/> |

Thyroid condition	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Metal bone pins or plates	<input type="checkbox"/>
Heart problem	<input type="checkbox"/>	Phlebitis, blood clots, poor circulation	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	Blood clotting abnormalities	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Psychological treatment	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	Keloid scarring	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Skin disease/skin lesions	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	Fever blisters	<input type="checkbox"/>
Any active infection	<input type="checkbox"/>		

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

8) Do you smoke? No Yes

9) Do you follow a restricted diet? No Yes, specify: _____

10) Do you follow a regular exercise program? No Yes

11) What is your stress level? High Medium Low

List any medications you take regularly: _____

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

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? No Yes, describe: _____

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

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

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

16) 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 _____

17) Do you experience any problems sleeping? No Yes

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

19) Do you wear contact lenses? No Yes

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

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

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

23) Have you ever experienced claustrophobia? No Yes

24) Do you suffer from sinus problems? No Yes

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

Rash Irritation Peeling Sun Sensitivity Breakout

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

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs
Fragrance Shellfish Latex Drugs Other: _____

If yes, please explain: _____

Female Clients Only:

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

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

29) Are you pregnant or trying to become pregnant? No Yes

30) Are you lactating? No Yes

31) Any menopause problems? No Yes, specify: _____

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

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.

Client Signature: _____ Date: _____