Client Information & Medical History

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ E-Mail: _____

Cell Phone: (_____) _____ Home Phone: (____) _____

Other Phone: (____) _____

Emergency Contact Name & Phone: _____

Do you regularly sunbathe or use tanning salons? _____ How Often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? YES NO

If yes, for what? _____

_____

Do you have any of the following medical conditions? Please check all that apply:

Cancer (if so, when: _____)

Diabetes

High Blood Pressure

Herpes

Arthritis

Frequent Cold Sores

HIV/AIDS

Keloid Scarring

Skin Diseases/Skin Lesions

Seizure Disorder

Hepatitis

Hormone Imbalance

Thyroid Imbalance

Blood Clotting Abnormalities

Taking blood thinning medications other than aspirin

Any active infections

Pacemaker, any implanted devices, pain pumps or stimulators

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

_____

Have you ever had an allergic reaction? Please list any/all reactions you have had before and describe the reaction you experienced.

NONE

Food _____

Animal Protein _____

Aspirin _____

Antibiotics _____

Lidocaine _____

Hydrocortisone _____

Hydroquinone (skin bleaching agent) _____

Medication reaction _____

Other: _____

_____

_____

MEDICATIONS

The following medication questions are to screen for potential issues with blood clotting which can occur with certain medications.

What oral medications are you presently taking? Birth Control Pills Hormones Antibiotics Thyroid Medication Steroids Autoimmune medications

Others: _____

_____

Do you take any medications for heart conditions? NO YES _____

_____

Are you on any medications for anxiety or depression? Mood altering medications?

NO

YES _____

Do you use any topical medications or creams are you currently using? Retin A Antibiotics Glycolic Acid Salicylic Acid Other (Please List):

_____

_____

What herbal supplements do you use regularly? NONE

GYNECOLOGIC HISTORY (Female Clients Only)

Are you pregnant or trying to become pregnant NO YES
Are you breastfeeding? NO YES
Are you using contraception? NO YES
Do you have an IUD? NO YES Name/brand: _____

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

Signature: _____ Date: _____