Confidential Client Medical/Skin Care History

Name:_____ Today's Date:_____

Address: _____

City: _____ State: _____ Zip:_____

Contact Phone: _____ E-mail: _____

Birthday:_____ Emergency Contact:_____ Phone:_____

What are your goals and expectations for today's skin care or massage session? _____

_____

Your Health:

Are you currently under a doctor's care? Y ☐ N ☐ For what ailment or reason _____

Please list any surgeries or medical procedures you have undergone within the last year:

_____

Please list any health issues you are experiencing now or within the last 2 years:

_____

Medications you take regularly _____

Vitamins or Supplements you take regularly _____

Do you smoke? Y ☐ N ☐ Do you exercise regularly? Y ☐ N ☐ Do you wear contact lenses? Y ☐ N ☐

Do you have metal implants, a pacemaker, or body piercings? Y ☐ N ☐ Where? _____

Are you pregnant or trying to become pregnant? Y ☐ N ☐ Are you lactating? Y ☐ N ☐

Are you on hormone therapy (HRT or BC pills)? Y ☐ N ☐

Your Skin:

What concerns do you have regarding your face or body today? _____

_____

_____

Please check the skin care products are you currently using on your face:

Soap ☐ Cleanser ☐ Toner ☐ Moisturizer ☐ Masque ☐ Exfoliator ☐ Eye Products ☐

Exfoliation History:

Have you ever had chemical peels, microdermabrasion or any resurfacing procedure? Y ☐ N ☐
Within the last 30 days? Y ☐ N ☐ How did you respond? _____

Do you use Accutane, Retin A, Renova, Adapalene or other prescription products? Y ☐ N ☐
Within the last 3 months? Y ☐ N ☐ How did you respond? _____

Are you currently using any products containing the following ingredients?
Glycolic acid ☐ Lactic acid ☐ Exfoliating scrubs ☐ Hydroxy Acid ☐ Vitamin A ☐

How much water do you drink daily? _____ Alcoholic beverages _____
What is your normal daily caffeine intake? (tea, coffee, soft drinks) _____

Do you ever experience these conditions? Flakiness ☐ Tightness ☐ Obvious Dryness ☐

Do you sunbathe or use tanning beds? Y ☐ N ☐ What SPF sunscreen do you use? _____

Sensitivity or Capillary Activity:

Do you burn easily in moderate sunlight? Y ☐ N ☐ Do you blush easily? Y ☐ N ☐

Do you have a tendency to redness? Y ☐ N ☐ Do you have sinus issues? Y ☐ N ☐

Oil Secretion:

Do you experience oily shine during the day? Y ☐ N ☐ OCCASIONALLY ☐

Do you experience breakouts? Y ☐ N ☐ OCCASIONALLY ☐ (Nose ☐ Chin ☐ Forehead ☐ Cheeks ☐)

Do you experience burning, itching, stinging or other skin irritations regularly? Y ☐ N ☐

Are you allergic to any substances, including medications or cosmetics? Y ☐ N ☐ Please explain:

_____

Waxing:

Have you ever had waxing performed anywhere on your body? Y ☐ N ☐
Are you currently having or due for your menstrual period? Y ☐ N ☐
Have you started any new medications since your last waxing? Y ☐ N ☐
Do you experience ingrown hairs or irritation? Y ☐ N ☐

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any pertinent information that my be relevant to my treatment and will advise the staff of any health changes.

Signature _____ Date _____