Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dermatologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Questionnaire**

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? \_\_\_\_\_\_\_ If yes explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Any recent surgery, including plastic surgery? \_\_\_\_ No \_\_\_\_ Yes, If yes explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Any skin cancer? \_\_\_\_No \_\_\_\_ Yes, if yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Conditions**

Check mark if you have/had any of these health conditions in the past or present? Specify if needed it.

|  |  |
| --- | --- |
| * Cancer * Hormone Imbalance * Systemic Disease * High Blood Pressure * Spinal Injury * Thyroid Condition * Hysterectomy * Diabetes * Heart Problem * Varicose Vein * Arthritis * Asthma * Eczema * Epilepsy * Seizure Disorder * Fever | * Headaches * Hepatitis * Herpes * Frequent Cold Sores * Immune Disorders * HIV/AIDS * Lupus * Metal Bone/Pins/Plates * Phlebitis/Blood Clots/Poor Circulation * Blood Clotting Abnormalities * Psychological Treatment * Insomnia * Keloid Scarring * Skin Disease/Lesions * Any Active Infection * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

4) Do you have any piercings, or tattoos in the area you will like to treat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) Do you wear contact lenses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Do you smoke or drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Continue Health Questionnaire**

7) Do you follow a healthy diet?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8) How often do you exercised in a weekly basis? \_\_\_\_\_\_\_\_\_\_\_Days/Week # \_\_\_\_\_\_\_\_\_\_Hours/Minutes

9) What is your stress level? \_\_\_\_ Low \_\_\_\_Medium \_\_\_High

10) List any prescribe medications you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11) List any over the counter medications/vitamins/supplements you taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12) Do you form thick or raised scars form cuts or burns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13) List your daily consumption of Water \_\_\_\_\_\_\_\_/glasses per day Coffee \_\_\_\_\_\_\_/cups per day

14) Do you have sleeping problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many hours do you sleep at night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15) Do you have metal Implants?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16) Do you suffer from sinus problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17) What medications you are allergic to?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18) List any allergies you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19) Have you ever had any of the following adverse reaction after using any skin care product?

\_\_\_\_\_Rash \_\_\_\_\_Itch \_\_\_\_Irritation \_\_\_\_Peeling \_\_\_\_Sun Sensitivity \_\_\_Break out.

20) How do you describe your overall health? \_\_\_\_ Poor \_\_\_Fair \_\_\_\_ Good

*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 X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_