Whitney Lopez
MEDICAL AESTHETICS

CLIENT INFORMATION & MEDICAL HISTORY

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

Today's Date _____

Personal information

Client name _____

Date of birth _____ Age _____

Address _____ City/St/Zip _____

Home phone _____ Work phone _____ Cell phone _____

E-mail _____

Emergency Contact Name _____ Phone _____

Occupation _____

How were you referred to us? _____

Skincare history

Which of the following best describes your skin type when exposed to the sun for about 1 hour with no protection? (choose one)

I. Always burn, never tan
II. Usually burn, sometimes tan
III. Sometimes burn, always tan
IV. Rarely burn, always tan
V. Brown pigmented skin
VI. Black pigmented skin

Do you blush easily when nervous? yes no

Do you have a tendency to redness? yes no

What skin care product line are you currently using? _____

Please indicate any areas of concern:

Fine lines and wrinkles
Acne and other scars
Brown spots / sun damage
Oil / acne
Unwanted hair
Skin texture
Firm / tighten facial tissue
Redness / rosacea
Improve hydration
Skin tags / skin irregularities
Pore size
Smile lines / vertical lip lines

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Medical history

Are you currently under the care of a physician or dermatologist? yes no

If yes, for which conditions:

Do you have a history of *erythema abigne* (a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation)? yes no

Do you have any of the following medical conditions? (check all that apply)

- Cancer
- Diabetes
- High blood pressure
- Herpes
- Arthritis
- Frequent cold sores
- HIV / AIDS
- Keloid scarring
- Skin disease / skin lesions
- Seizure disorder
- Hepatitis
- Hormone imbalance
- Metal implant(s)
- Pacemaker
- Thyroid imbalance
- Blood clotting abnormalities
- Any active infection

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

Have you ever had an allergic reaction to any of the following? (check all that apply and describe the reaction you experienced)

- Food
- Latex
- Aspirin
- Lidocaine
- Hydrocortisone
- Hydroquinone or skin bleaching agents
- Other allergies

Describe reaction _____

Medications

What medications are you presently taking? Birth control pills Hormones Others (list):

_____

Are you on any mood altering or anti-depression medication? yes no

Have you ever used Accutane? yes no

If yes, when did you last use it? _____

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What topical medications or creams are you currently using? Retin-A Others (list)

_____

What herbal supplements do you use regularly? _____

History

Have you ever had laser hair removal? yes no

Have you used any of the following hair removal methods in the past six weeks?

Shaving	Tweezing
Waxing	Stringing
Electrolysis	Depilatories

Have you had any recent tanning / sun exposure that changed the color of your skin? yes no

Have you recently used any self-tanning lotions or treatments? yes no

Do you form thick or raised scars from cuts or burns? yes no

Do you have *hyperpigmentation* (darkening of the skin) or *hypopigmentation* (lightening of the skin) or marks after physical trauma? yes no

If yes, please describe: _____

When were you last exposed to the sun (or tanning booth)? _____

Have you had any skin resurfacing or rejuvenation or chemical peels? yes no

Do you currently have any permanent make up? yes no

Have you ever had treatments for pigmented lesions? yes no

Have you ever had treatments for unwanted veins? yes no

For female clients only

Are you pregnant or trying to become pregnant? yes no

Are you breastfeeding? yes no

Are you using contraception? yes no

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Patient Signature _____ Date _____

(type name for electronic signature)