BD______________________________

Client History

Date:___________

Name: ____ Date of Birth: _____________Age: _____

Address: ____

City State Zip

Cell Phone:____________________ Home Phone: ____________________Work Phone: __________________

Email Address: ____ ☐ Female ☐ Male

Emergency Contact: ____________________________ Phone Number: _____________________________

How did you hear about us? __________________________________ SS #_______________________

Packages purchased are non-refundable, but are transferable to another procedure or product within the clinic.

What concerns would you like to have addressed?

☐ Sun Damage ☐ Redness ☐ Scars ☐ Acne ☐ Excess fat or cellulite ☐ Sagging skin ☐ Veins ☐ Spray Tan

☐ Skin Lesions ☐ Wrinkles ☐ Skin texture ☐ Latisse ☐ Unwanted hair ☐ Preventative Medicine

☐ Permanent cosmetics: ☐ Eyebrows ☐ Eyeliner ☐ Areola ☐ Lightening Other:______________________

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and describe what happened below.

☐ **NONE** ☐ Tattoo ink/pigment ☐ Novocaine, Lidocaine ☐ Benzocaine, Tetracaine

☐ Lanolin
☐ Tape ☐ Bacitracin ointment ☐ Neomycin ☐ PABA ☐Aspirin ☐ Sulfa

☐ Latex rubber ☐ Metal ☐ Cold sores ☐ Alpha-hydroxy acid ☐ Preservatives
☐ Hydroquinone ☐ Sun

☐ Foods (including eggs & milk): ____

☐ Drugs____

Other allergies (including environmental): ____

Reaction: ____

FOREHEAD/EYES/EYEBROWS: Check all of the following that apply.

☐ Contact lenses ☐ Dry eyes ☐ Eye makeup sensitivities ☐ Blurred Vision

☐ Glaucoma ☐ Lasik /eye surgery ☐ Thyroid abnormalities ☐ Alopecia Areata (local)

☐ Alopecia Universalis (total) ☐ Pull out lashes/eyebrow compulsively (Trichotillomania)
☐ Ptosis (eyelid droop) ☐ Uneven Brows ☐ Scar

☐ Other hair loss (describe): ____

☐ Eyebrow/Lash tinting
Date of last service: _____________

☐ Botox / Dysport
Date of last service:_____________________________

Other eye disorders:____

LIPS: Check all of the following that apply.

☐ **Cold sores**/fever blisters/herpes ☐ Botox/Dysport :Date:

☐ Dermal filler/Lip injections - Type: _______________ Date: ___________________________

☐ Other lip augmentation - Type: _________________ Date: ___________________________

SKIN: Check all of the following that apply.

- ☐ Tattoo/location: ____________________ Any problems?: ____________________
- ☐ Currently/recent use:(circle) Retin-A Renova Differin Hydroquinone Fade cream
- ☐ Use of sunlamp/tanning bed/suntan outdoors
- ☐ Currently using glycolic or salicylic acids?
- ☐ Injectables such as Restylane, Juvederm or other fillers? ____________________
  Do you use sunscreen on face/neck? ☐ Always ☐ Sometimes ☐ Never
- ☐ Ever had a chemical peel? When:__________ Type: Glycolic ☐ Laser ☐ TCA ☐ Phenol ☐ Jessner ☐ Other
- ☐ Do you have a scar you want camouflaged? Age of Scar: ____________________
- ☐ History of skin cancer or pre-malignant moles: where/when____________________
- ☐ Do you bruise or bleed easily?
- ☐ Do you have healing problems?
- ☐ Any keloid or hypertrophic scars? - Location: ____________________
- ☐ Previous electrolysis, waxing, or laser hair reduction? _______ When?_________ Where?________
- ☐ Previous laser vein reduction? Y N
- ☐ Schlerotherapy (injection)
- ☐ Other active skin disorders? Psoriasis, eczema, rashes, vitiligo, herpes simplex , acne, or other
  Describe: ____________________

GENERAL MEDICAL: Check all of the following that apply.

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Pregnant or nursing or planning soon
- ☐ Taken Accutane within the last 6 month
- ☐ History of Cancer
- ☐ Recent use of tetracycline, aminoglycosides or St John's Wort
- ☐ Birth control or hormone replacement
- ☐ Asthma
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Heart Palpitations, pacemaker or defibrillator
- ☐ Mitral valve prolapse or valve implants
- ☐ Hemophilia or other clotting disorders
- ☐ Metal or implants in area to be treated
- ☐ History of Botulism immunization
- ☐ Recent use of anti-malaria medications
- ☐ History of conditions affected by flashing light
- ☐ Smoke? How long? ____________________
- ☐ Hives
- ☐ Currently on blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofen, alcohol, Vit. E?
  ____
- ☐ Autoimmune or neuromuscular disorders - describe: ____________________
- ☐ Do you have a condition such as Hepatitis, HIV or undergoing treatment such as chemotherapy that could affect healing?____________________
- ☐ Current/Past Military Enlistment
- ☐ Seizures - describe: ____________________
- ☐ Use of medications or herbs known to induce photosensitivity to light?
  ____
- ☐ Current use of controlled substances - describe: ____________________

Please list any surgeries: ____________________

Are you planning cosmetic or other surgeries/procedures in the near future, describe: ____________________

____

List all medications, prescription and non-prescription that you are taking, including vitamins & supplements:

____

____

If you are currently under a physician's care for any condition, describe: ____________________

Physician's Name: ____________________City: ____________________ Phone: ______________

I have carefully reviewed this history and find it to be correct to the best of my knowledge.

Client Signature:____Date:________________

Skin Type Worksheet

THIS INFORMATION IS REQUIRED FOR SKIN ANALYSIS

Your Ethnicity: ____

When was the last time you had significant sun exposure? ____

Are you currently tan? ☐No ☐Yes Do you ever tan artificially? ☐Tanning Bed ☐Sprays/Lotions ☐None

Score	Analysis	0	1	2	3	4
	What is the color of your eyes?	Light Blue, Grey, or Green	Blue, Grey, or Green	Blue	Dark Brown	Brownish Black
	What is the natural color of your hair?	Sandy Red	Blond	Chestnut or Dark Blond	Dark Brown	Black
	What is the color of your skin in unexposed areas?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun for too long?	Painful redness and blistering followed by peeling	Blistering followed by peeling	Burn, sometimes followed by peeling	Rarely Burn	Never Burn
	To what degree do you turn brown?	Hardly or not at all	Light colored tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never a problem
	When did you last expose yourself to the sun, tanning bed, or tanning cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
TOTAL:	Score / Skin Type 0-7 / I 8-16 / II 17-25 / III 25-30 / IV Over 30 / V-VI					

Which of the following best describes your skin?

TYPE: □ Very Oily □ Oily □ Combination □ Dry Cheeks □ Normal □ Dry

BREAKOUTS: □ Almost Always □ Frequently □ Monthly □Rarely □ Never

SENSITIVITY: □ Sensitive/Reactive □ Mostly Normal □ Thicker/Tougher

11/14