BARE BEAUTY

laser + skin studio

Confidential Client Health History Form

Name: ____ **Date of Birth:** ______________________________

Address: ____
Street Apt/Ste/Fl City/Town State Zip

Primary Phone:______________________________________ **Email:**____

Emergency Contact Info: ____
Name Phone

Physician Contact Info: ____
Name Phone

Have you been under the care of a physician, dermatologist, or other medical professional within the past year?

If yes, please explain: ____

Any recent surgery, including plastic surgery? If yes, please explain: _____________________________________

____

Any skin cancer? If yes, please explain: ____

____

Do you have any piercings, tattoos, or permanent cosmetics? If yes, where on your person? ___________________

____

Have you ever had a body spa treatment before? If yes, when? ____

Have you had any of the following health conditions in the past or present? Please circle all that apply:

Cancer Headaches (Chronic) Hormone Imbalance Hepatitis Systemic Disease Herpes Spinal Injury

High Blood Pressure Frequent Cold Sores Immune Disorders Thyroid Condition Hysterectomy

HIV/AIDS Lupus Diabetes Metal bone pins or plates Heart Problem Varicose Veins Arthritis

Phlebitis, blood clots, poor circulation Blood clotting abnormalities Asthma Psychological Treatment

Eczema Insomnia Epilepsy Keloid Scarring Seizure Disorder Skin Disease/Lesions Fever

Blisters Any active infection Other: ____

If you circled one or more of the above, please explain: ____

____

Has your physician ever discussed concerns about raising your body temperature? If yes, please explain:

____

Do you smoke? NO YES **Do you follow a restricted diet?** NO YES, I follow: ________________________________

Do you follow a regular exercise program? NO YES **What is your stress level?** HIGH MEDIUM LOW

List any medications you take regularly: ____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicyclic Acid, or Retinol/Vitamin A Derivative products? If yes, please specify: ____

Have you used any of these products in the last three months? NO YES

Have you used any acne medication? If yes, please specify type and when: _______________________________________

Do you form thick or raised scars from cuts or burns? NO YES

Do you have hyperpigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin) or marks after physical trauma? If yes, please describe: ____

List your daily consumption of water: _________________ **caffeine:** __________________ **alcohol:** __________________

Do you experience problems sleeping? NO YES **How many hours do you typically sleep per night?** ___________

Do you wear contact lenses? NO YES **Have you experienced claustrophobia?** NO YES

Have you been to a tanning bed in the last 48 hours? NO YES

How frequently are you exposed to the sun or used a tanning bed? FREQUENTLY INFREQUENTLY

Do you have any metal implants or wear a pacemaker? NO YES **Do you suffer from sinus problems?** NO YES

Have you ever had an adverse reaction from a skincare product? If yes, please explain: ___________________________

____

Please circle if you are allergic or have ever had an allergic reaction to the following:

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs Fragrance Shellfish

Latex Drugs Other: ____

If you circled any of the above, please explain: ____

____

Female Clients Only:
Are you taking oral contraceptives? NO YES, I take ____

Any recent changes to or from your contraceptive treatment? If yes, please explain the change(s) and when:

____

Are you pregnant, or trying to become pregnant? NO YES **Are you lactating?** NO YES

Any menopause problems? If yes, please specify: ____

Please use this space to complete answers where space provided was insufficient (please specify which question):

____

____

____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes and 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: ____

Date: ____