



PATIENT INFORMATION & MEDICAL HISTORY

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

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons? _____ How often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, for what: _____

Do you have any of the following medical conditions? (Please 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 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? (List any and all that you have had and describe the reaction you experienced) Food Animal Protein Aspirin Lidocaine

Hydrocortisone Hydroquinone or skin bleaching agents Others: _____

MEDICATIONS

What oral prescription medications are you presently taking? Birth control pills Hormones
 Others (It is required that you list all of them): _____

What antibiotics do you use to treat infections? _____

Do you take any medications for heart conditions? _____

Are you on any mood altering or anti-depression medication? _____

What topical medications or creams are you currently using? RetinA , Others (Please list): _____

What herbal supplements do you use regularly? _____

HISTORY

For our female clients:

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, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date: _____