CONFIDENTIAL HEALTH HISTORY

Name:_____

Address: _____

Preferred Phone: _____

Email address: _____

Employer: _____ Occupation: _____

Does your job require that you work outdoors? No Yes

Referred by: _____ Date of Birth: _____

Physician: _____Phone: _____

Emergency Contact: _____Phone: _____

Your Health:

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

NO YES Please explain: _____

Any recent surgery, including plastic surgery?

NO YES Please explain: _____

Any skin cancer?

NO YES Please explain: _____

Have you had any piercings, tattoos, or permanent cosmetics?

NO YES Please explain: _____

Have you had any of these health conditions in the past or present? (Please circle all that apply and provide additional information in the space provided)

Cancer
Hormone imbalance
Systemic disease
High blood pressure
Spinal injury
Thyroid condition
Hysterectomy
Diabetes
Heart problem
Varicose veins
Arthritis
Asthma
Eczema
Epilepsy
Seizure disorder
Fever blisters
Headaches (chronic)
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/skin lesions
Any active infection

Do you smoke? NO YES

Do you follow a regular exercise program? NO YES

Do you follow a restricted diet?

NO YES Please explain: _____

What is your stress level? High o Medium o Low o

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, Salicylic Acid or Retinol/vitamin A derivative products?

NO YES Please explain: _____

Have you used any of these products in the last 3 months? NO YES

Have you used an acne medication?

NO YES Please explain (including medication): _____

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

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?

NO YES Please explain: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

Do you experience any problems sleeping? NO YES

How many hours do you typically sleep each night? _____

Do you wear contact lenses? NO YES

Have you been exposed to the sun or used a tanning bed in the last 48 hours? NO YES

How frequently are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___Regularly

Do you have any metal implants or have a pacemaker? NO YES

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics	*Sunscreens*	*Fragrance*	*Other:*
Medicine	*Iodine*	*Shellfish*	_____
Food	*Pollen*	*Latex*	
Animals	*AHAs*	*Drugs*	

If yes, please explain: _____

Female Clients Only: Are you taking oral contraceptives?

NO YES Please explain: _____

Any recent changes to or from your contraceptive treatment?

NO YES Please explain (including what and when):_____

Are you pregnant or trying to become pregnant? NO YES

Are you lactating? NO YES

Any menopause problems?

NO YES Please explain: _____

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____
_____
_____
_____
_____

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 at Kara's Beauty Barn 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:_____