

## CLIENT 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: \_\_\_\_\_