CLIENT HEALTH RECORDS

Client Ref:

Name: | Date:

Address:

Zip Code:

Home: | Work: | Cell:

Email: | Occupation: | Date of birth:

Gender: ◯ Male ◯ Female

Please answer *yes* or *no* to the questions below and any relevant details.

	YES	NO	IF YES, PLEASE GIVE DETAILS
For females only			
Are you pregnant? Are you lactating?	◯	◯	
For everyone			
Are you under Physician's care for any severe medical condition?	◯	◯	
Do you have any hormonal imbalance?	◯	◯	
Do you have any burns/grafted skin?	◯	◯	
Do you have diabetes?	◯	◯	
Do you have epilepsey?	◯	◯	
Do you have kidney disease?	◯	◯	
Do you have Port Wine Hemangioma?	◯	◯	
Do you have shingles?	◯	◯	
Do you have Thyroid Hormone condition?	◯	◯	
Do you experience acne?	◯	◯	
Do you or have you experienced cold sores?	◯	◯	
Do you have keloid scar fomation?	◯	◯	
Have you ever been diagnosed with melanoma?	◯	◯	
Do you have psoriasis/Eczema/Dermatitis?	◯	◯	
Are you being treated for any other condition?	◯	◯	
Are you taking any medication/Natural Remedies?	◯	◯	
Have you ever used (or using) Retin A?	◯	◯	
Have you ever used (or using) Roaccutane/Isotretinoin?	◯	◯	
Have you had laser/Chemical Peels in the last 6 months?	◯	◯	
Have you any tattoos or permanent makeup in the are to be treated?	◯	◯	
Have you recently had facial implants?	◯	◯	
Are you currently using Glycolic Acid-based products?	◯	◯	
Are you currently using Steroids or Steroid Cream products?	◯	◯	
Are you currently using Hydroquinone (skin lightening products)?	◯	◯	
Do you have any allergies, including aspirin?	◯	◯	
Have you been exposed to the sun for long periods of time within the past 2 weeks?	◯	◯	
Do you have asthma?	◯	◯	
Do you have high blood pressure?	◯	◯	
Do you have a heart condition?	◯	◯	

Client Signature | Date

Print name

Section 3