Client Health History: Electrolysis Health History Intake

Name: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip: _____

Home/Cell Phone:_____ Work: _____

Email:_____ Preferred Contact: Cell____ Work ____ Email _____

Emergency contact name: _____ Phone _____

Relationship to you: _____

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

- ❑ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
- ❑ II. Fair skinned; light hair, light eyes
- ❑ III. Very common skin type; fair; eye and hair color vary
- ❑ IV. Mediterranean Caucasian skin; medium to heavy pigmentation
- ❑ V. Mideastern skin; rarely sun sensitive
- ❑ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❑ Yes ❑ No

Please list the products you use regularly:

Facial Cleanser _____ Moisturizer _____

Toner _____ Serum _____

Scrubs _____ Sunscreen _____

Retinol _____ Glycolic Acid _____

Enzymes_____ Peptides or Growth Factors _____

Cosmetic History

How would you describe your skin? Normal___ Combination___ Oily___ Dry____

When were you last exposed to the sun (including tanning beds)? _____

Do you use sunless tanning products? Yes ____ No ____ If yes, when was it last applied? _____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes ___ No___ If yes, please describe _____

_____

Have you had electrolysis treatments in the past? Yes ___ No___ If yes, when were you last treated, what area was treated, and for how long were you receiving treatments? _____

_____

Continued ⇨

Are you currently using or have you used in the past year any of the following?
____Acyclovir ____Hydroquinone ____Tretinoin (Retinoic Acid) ____Adapalene (Differin) ____Isotretinoin (Accutane)
If yes, when? _____

Are you using any topical creams, lotions, or oral antibiotics for acne, cancer, antiaging or hyperpigmentation?
Please List: _____

Have you ever had any of the following injectables or implants?

Botox	Radiesse	Perlane	Collagen	Dysport
Juvederm	Restylane	Silicone	Sculptra	

Other: _____

If yes, when? _____ What body area(s)? _____

Have you had any surgeries/cosmetic procedures, piercings, metal implants, tattoos, or use of a pacemaker within the past year? Yes ___ No___ If yes, when? _____

Have you used any of the following hair removal methods in the past six weeks?
___Shaving ___Waxing ___Tweezing ___Threading ___Depilatories

Health History

Do you smoke or use any tobacco products? Yes___ No___
Have you been treated for cancer or received chemotherapy treatments in the last year? Yes___ No___
Do you have any allergies to medications, food, latex, topical products, and/or other substances? _____
_____

Do you have any of the following conditions?
____ Acne or dermatitis _____ Rosacea ___Hormone imbalance and/or endocrine disorder
____ Pregnant or breastfeeding ____Autoimmune disease ____Herpes Simplex (cold sores)
____Diabetes ____ High blood pressure ____ Hepatitis or blood clotting disorders
Do you have any other health condition not mentioned here? Yes___ No___ If yes, please list _____
_____

Are you currently on birth control? Yes___ No____ If yes, please describe _____
Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___
Please list all vitamins and supplements including herbal remedies you take regularly _____
_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____
_____

Is there anything else you would like us to know? _____
_____

Continued ⇨

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) _____

Client Name (Signature) _____ Date: _____

Esthetician/Technician: _____ Date: _____