Client Health History: Laser/ Light Energy 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 laser treatments in the past? Yes ___ No___ What body area was treated? _____

_____

Describe your experience _____

Continued ⇨

Have you used Accutane in the past year? Yes____ No____

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 other cosmetic surgeries/procedures? Yes ___ No___ If yes, when?_____

What body area?_____

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

Health History

Have you had chemotherapy in the past 6 months? Yes___ No___

Do you have moles/skin growths in the area to be treated? Yes___ No___

Have you ever had a reaction at the dentist or any other time from numbing? 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:

___ Epilepsy ____Eczema ____Dermatitis ___Hormone imbalance ____Pregnancy and/or breastfeeding

____Autoimmune disease ____Herpes Simplex ____Diabetes

Do you have any other health condition not mentioned here? Yes___ No___ If yes, please list _____

_____

Do you form thick or raised scars from cuts or burns? Yes___ No___

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Have you undergone any recent surgery? Yes___ No___ If yes, please explain _____

_____

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? _____

_____

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: _____