

**Client information and Medical History**

**In order to provide you with the most appropriate treatment, please complete the following questionnaire.** 

**All information is strictly confidential.**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_\_\_\_ Sex \_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Do you have any of the following medical conditions?

\_\_ Cancer \_\_Hepatitis

\_\_ Diabetes \_\_Hormone Imbalance

\_\_ High Blood Pressure \_\_Thyroid Imbalance

\_\_ Herpes Simplex \_\_Blood Clotting

\_\_ Frequent Cold Sores \_\_Keloid Skin Lesions

\_\_ HIV/AIDS \_\_Eczema

\_\_ Depression \_\_Psoriasis

\_\_ Auto- Immune Disorder \_\_Sinus

\_\_ Vitiligio \_\_Seizure Disorder

\_\_ Pacemaker/Defibrillator \_\_Arthritis

\_\_ Smoker \_\_Neurological Disorder

\_\_Stroke \_\_Muscle Weakness

\_\_ Paralysis

Are you currently under the care of a Physician or Dermatologist? Yes/ No: If yes, for what?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other current or past health problems or medical conditions? If yes, what?

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Did you previously/recently had cortisone treatment? If yes, when?

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Please list any known allergies, and/ or past allergic reactions:

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Have you had any surgeries? Yes/ No: If yes, for what?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**

Please list all oral and topical medications you are presently taking: (including **anti-biotics**, hormone therapy, blood thinners, mood altering medications OTC medications)

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Please list all vitamins and/or herbal supplements you are presently taking:

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Have you ever had any of the following?

Laser Hair Removal / Electrolysis / Waxing / Tweezing / IPL Treatment \_\_

Photo facials / Fractional Laser / CO2 Laser / Laser Surgery / Collagen or Other Fillers /Vampire facial \_\_

Cosmetic Surgery / Botox or Dysport / Facials /Chemical Peels / Microdermabrasion / Dermaplaning / Threading \_\_

And when last did you have the treatment done?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle**

Do you smoke? \_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_

Do you drink? \_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_

Are your activities mostly indoor or outdoor? Circle one

How many times a week do you exercise? \_\_\_\_\_\_\_\_\_

**Only for female patients**:

Are you currently on Birth Control? Yes No

Are pregnant or lactating? Yes No

Are you trying to become pregnant? Yes No

Did you get hyperpigmentation or pregnancy mask during your pregnancy? Yes No

Are you menopausal? Yes No

When was the last day of your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**