CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment,
we ask that you complete the following questionnaire. All information is strictly confidential.

CLIENT INFORMATION

Name:_____ Date:_____

Date of Birth ___/___/_____ Age _____ Occupation_____

Address_____

City/State _____ Zip_____ Home Phone (_____)_____-_____

Cell Phone (_____)_____-_____ Email Address_____

Emergency Contact Name & Phone _____

How were you referred to IMAj? _____

MEDICAL HISTORY

Are you currently under the care of a physician/dermatologist? ☐ Yes ☐ No

If yes, what for:_____

Do you have a history of erythema abigne? (A persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation.) ☐ Yes ☐ No

Do you have any metal implants or artificial joints? ☐ Yes ☐ No
If yes, explain:_____

Have you ever had an allergic reaction to any of the following:
☐ Latex☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone ☐ Hydroquinone
☐ Lavender ☐ Pumpkin
If so, please describe your reaction:_____

Please list any other allergies or sensitive's you've experienced, including food:

_____

List any surgeries you have had and how long ago:_____

MEDICATIONS

List any oral medications you are presently taking: *(Please include what they are treating & how frequently they are taken)*

_____

_____

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What topical medications or retinoid creams are you currently using?

_____

What herbal supplements do you use regularly?

_____

Do you have or have you ever had any of the following medical conditions?
(Please check all that apply)

☐ Cancer (Type) _____ ☐ Diabetes ☐ High Blood Pressure ☐ Herpes

☐ Frequent Cold Sores ☐ HIV/AIDS ☐ Keloid Scarring ☐ Skin disease/Skin lesions

☐ Syphilis ☐ Seizure disorder ☐ Hepatitis (Type)_____ ☐ Hormone Imbalance

☐ Arthritis ☐ Blotting clotting abnormalities ☐ Thyroid Imbalance/Disorder

☐ Implantable Defibrillators ☐ Pacemaker ☐ Vitiligo ☐ Emotional/Psychiatric

☐ Auto Immune Disease ☐ Gonorrhea ☐ Chlamydia ☐ Any active infection

☐ Connective Tissue Disorder ☐ Renal (kidney) Failure ☐ Lung disease or Tuberculosis

☐ Heart Issues: _____ ☐ CHF (Congestive Heart Failure)

If you checked any of the above boxes, how long ago were you diagnosed?_____

Do you have any other health problems of medical conditions? Please list:_____

_____

PERSONAL HISTORY

What is your ethnic background? _____

*Knowledge of ethnic background is necessary to properly determine safe treatment services and settings.

Have you ever used Accutane? ☐ Yes ☐ No
If yes, when did you last use it? _____

Have you ever had a chemical peel, laser or energy based treatment? ☐ Yes ☐ No
Explain: _____ How long ago:_____

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Besides shaving, have you used any of the following hair removal methods in the past six weeks?
☐ Waxing ☐ Electrolysis ☐ Tweezing ☐ Depilatories

Have you had any recent tanning or sun exposure, or used any self-tanning lotions or treatments that changed the color of your skin? ☐ Yes ☐ No

Do you have hyper-pigmentation (darkening of skin) or hypo-pigmentation (lightening of skin), raised scars, or marks after physical trauma? ☐ Yes ☐ No If yes, explain:_____

Do you have permanent make-up? ☐ Yes ☐ No If yes, where:_____

Have you had dermal fillers or Botox injections? ☐ Yes ☐ No If yes, how long ago and where? _____

Do you wear contacts? ☐ Yes ☐ No

Do you use oils on your skin? ☐ Yes ☐ No If yes, explain:_____

Do you develop cold sores/fever blisters? ☐ Yes ☐ No If yes, last breakout?_____

For our female clients:
Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No

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 technician, esthetician, therapist, doctor or nurse of my current medical conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Name: (please print) _____

Client Signature: _____ Date: ___/___/____

Technician Signature:_____ Date: ___/___/____

Instructor Signature: _____ Date: ___/___/____