Client Information & Medical History

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

Personal Information

Client Name _____Today's Date _____

Date of Birth _____Age_____Occupation_____

Home Address_____City_____State_____ZipCode_____

Home Phone (___) _____Work Phone (___) _____Cell Phone (___) _____

E-Mail Address _____@_____

Emergency Contact Name _____ Phone (___) _____

How were you referred to us? _____

Which of the following best describes your skin type when exposed to the sun for about 1 hour with no protection? (Please check one type number)

I. Always burn, never tan ☐	II. Usually burn, sometimes tan ☐	III. Sometimes burn, always tan ☐	IV. Rarely burn, always tan ☐	V. Brown pig-mented skin ☐	VI. Black pig-mented skin ☐

Do you blush easily when nervous? No ▼ Do you have a tendency to redness? No ▼

What skin care product line are you currently using?_____

Your Skin Type Is? (Please check only one)

Normal ☐ Dry/Dehydrated ☐ Oily ☐ Acne/Acne Prone ☐ Rosacea ☐

Please check any areas of concern:

Fine Lines and Wrinkles ☐
Acne and Other Scars ☐
Brown Spots/Sun Damage ☐
Oil/Acne ☐
Unwanted Hair ☐
Skin Texture ☐

Firm/tighten Facial Tissue ☐
Redness/Rosacea ☐
Improve Hydration ☐
Removal of Skin Tags or Skin Irregularities ☐
Pore Size ☐
Smile Lines, Vertical Lip Lines ☐

 Patient Signature: _____Date:_____

Original Skin Med Spa
6821 W 120th Ave Ste A
Broomfield, CO 80020
(303) 438-8555 www.originalskinclinic.com

Medical History

Are you currently under the care of a physician or dermatologist? □ Yes □ No
If yes, for what: _____
_____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? □ Yes □ No

Do you have any of the following medical conditions? (Please check all that apply)
□ Cancer □ Diabetes □ High blood pressure □ Herpes □ Arthritis □ Frequent cold sores □ HIV / AIDS
□ Keloid scarring □ Skin disease / Skin lesions □ Seizure disorder □ Hepatitis □ Hormone imbalance
□ Metal Implant(s) □ Pace Maker □ Thyroid imbalance □ Blood clotting abnormalities
□ Any active infection

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

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) □ Food □ Latex □ Aspirin □ Lidocaine □ Hydrocortisone
□ Hydroquinone or skin bleaching agents □ Other allergies: _____

Describe Reaction: _____

Medications

What medications are you presently taking? □ Birth control pills □ Hormones □ Others
(Please list): _____

Are you on any mood altering or anti-depression medication? _____

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

What topical medications or creams are you currently using? □ RetinA, □ Others (Please List):
_____

What herbal supplements do you use regularly? _____

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History

Have you ever had laser hair removal? □ Yes □ No

Have you used any of the following hair removal methods in the past six weeks?
□ Shaving □ Waxing □ Electrolysis □ Tweezing □ Stringing □ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? □ Yes □ No

Have you recently used any self-tanning lotions or treatments? □ Yes □ No

Do you form thick or raised scars from cuts or burns? □ Yes □ No

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: _____
_____

When were you last exposed to the sun (or tanning booth)? _____

Have you had any skin resurfacing or rejuvenation or chemical peels? □ Yes □ No

Do you currently have any permanent make up? □ Yes □ No

Have you ever had treatments for pigmented lesions? □ Yes □ No

Have you ever had treatments for unwanted veins? □ Yes □ No

For our female clients:

Are you pregnant or trying to become pregnant? □ Yes □ No

Are you breastfeeding? □ Yes □ No

Are you using contraception? □ 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 or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

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