CLIENT INFORMATION & MEDICAL HISTORY
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In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire.
All information is strictly confidential.

PERSONAL HISTORY

Patient Name: ____ Today's date ___________________

Date of Birth ________________________ Age ______ Occupation _______________________________

Home address _________________________________ City _____________ State ____ Zip ___________

Home phone _________________________ Cellular _________________ work phone _______________

Email address ____

Emergency Contact Name & Phone ____

How were you referred to us? ____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes ______ No ______

If yes, for what?

____

____

Are you currently under the care of a dermatologist? Yes ______ No ________

If yes, for what? ____

Do you have a history of skin cancer? Yes ______ No _______

If yes, where and what type? ____

Do you have any history of erythema abigne, which is 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 _____ Thryroid imbalance _____

Blood clotting abnormalities _____ Any active infection _____

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

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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 ____ Lidocaine ____ Hydrocortisone ____ Hydroquinone or skin bleaching agents ____

Others ____

Describe reaction ____

MEDICATIONS

What oral medications are you presently taking? Birth control _____ Hormone replacement _____

Are you currently taking antidepressants or mood alternating medications? ________________________

Please list any others: ____

HISTORY

Have you ever had hair removal? Yes ____ No ____ Please list type ____________________________

Have you used any of the following hair removal methods in the past six weeks?

Shaving ___ Waxing ___ Electrolysis ___ Plucking ____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: __________________________

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 responsibilty 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 for the caregiver to execute appropriate treatment prcoedures.

Signature ____ Date ______________________

SKIN CARE PROFILE PATIENT NAME: __________________ DATE:_________

HOME CARE

PLEASE PROVIDE BRAND NAME AND FREQUENCY OF USE FOR THE FOLLOWING:

CLEANSER: _______________________________ HOW OFTEN? ________________

TONER OR ASTRINGENT?_____________________ HOW OFTEN? ________________

DAY MOISTURIZER: ________________________ HOW OFTEN? ________________

SUNSCREEN: ______________________________ HOW OFTEN? ________________

NIGHT CREAM: ____________________________ HOW OFTEN? ________________

EYE CREAM/GEL: __________________________ HOW OFTEN? ________________

MASK? ___________________________________ HOW OFTEN? ________________

GLYCOLIC OR AHA: ________________________ HOW OFTEN? ________________

RETINOL, RENOVA, RETIN-A: _______________ HOW OFTEN? ________________

OTHER: ____

PROFESSIONAL TREATMENTS

FACIALS: YES ____ NO ____ HOW OFTEN? ________________

CHEMICAL PEELS: YES ____ NO ____

IF YES, LIST TYPE: GLYCOLIC, TCA, PHENOL) ____________________________

LAST TREATMENT DATE: ________________________

LASER OR LIGHT TREATMENTS: YES ____ NO ____

DEVICE USED: ____

HOW OFTEN? __________________________ LAST TREATMENT DATE: ___________

DO YOU HAVE HISTORY OF SKIN CANCER OR PRE-CANCER? YES ____ NO ____

NOTES:

____

____

____

____

Name: ______________________________

Please answer the following questions by circling the number which best describes you. Your clinician will total your score during the consultation.

Question	Answer	Score
My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	____
	Fair -skinned Caucasians with light hair and light eyes	____
	Pale-skinned Caucasians with dark hair and dark eyes	____
	Olive-skinned (Mediterranean, some Asian, some Hispanic)	____
	Dark-skinned (middle Eastern, Hispanic, Asian, some Africans)	____
	Very dark-skinned (African)	____
My eye color is:	Light Blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light Brown	3
	Brown	4
My natural hair color at 18 was:	Red	0
	Blonde	1
	Light Brown	2
	Dark Brown	3
	Black	4
The color of my skin that is not normally Exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light Brown	3
	Medium to dark brown	4
	Dark brown – black	5
If I go in the sun for an hour without sunscreen and have not been in the sun for weeks, my skin will:	Burn, then blister and peel	0
	Burn, then when burn resolves there is no color change	1
	Burn, then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just Tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6
When was the last time the treatment area was exposed to sun, tanning booths or artificial tanning cream?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	2
	Within the past week	3

Total Score: ____

If your score is:	Your skin type is:
0 – 3	1
4 – 7	2
8 – 11	3
12 – 15	4
16 – 19	5
20 – 24	6

Appointment Cancellation Policy

Your appointments are very important to us at Aesthetic Skin Solutions. This time is reserved especially for you! We understand that sometimes schedule adjustments are necessary, especially during illness or emergencies; however, we respectfully request at least 24 hours notice for cancellations. Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and clients on our waiting list miss the opportunity to receive services. This is why appointments are confirmed 48 hours in advance. At our discretion, the following cancellation fees may apply when proper notice is not given.

FACIALS AND ELECTROLYSIS

Less than 24 hour notice of cancellation will result in a charge equal to 50% of reserved service amount. - “NO SHOWS” will be charged 100% of the reserved service amount

PERMANENT MAKEUP PROCEDURES

Permanent Makeup procedures require a 2-3 hour time slot on our schedule. When booking permanent makeup procedure(s) with Aesthetic Skin Solutions, a $100 deposit (cash or check only) is required. This is to hold your time slot. The $100 will be applied to the cost of your procedure provided cancellation policies are abided by as follows: - Appointment cancellations and reschedules: 48 hour notice is required. Otherwise, your $100 deposit will NOT be refunded. - “NO SHOWS” will be charged 100% of the reserved service amount

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Signature