Client Medical History Information

Name: _____ Birth Date: _____ /_____ /_____ Age: _____

Address: _____ Sex: M / F

City: _____ Post Code: _____

Home: (____) _____ Work: (____) _____ Mobile: (____) _____

E-mail: _____

Emergency Contact: _____ Telephone: (_____) _____

Allergies: _____

How did you hear about us? _____

:

Please put a check mark next to a past or current medical condition or treatment:

Medical History:

___ Lupus or other auto-immune deficiency
___ Pregnant
___ Graves Disease (Hyperthyroidism) Hashimoto's Disease (Hypothyroidism) and/or Treatment with Thyroxine
___ Bleeding abnormalities
___ Blood thinning medication (except low dose Aspirin)
___ Keloid or very thick scarring
___ Psoriasis or Vitiligo
___ Pulmonary embolism/blood clot
___ Leg ulcer or Phlebitis
___ Rheumatoid Arthritis "Gold" Therapy
___ Photodynamic Therapy (PDT) within last 3 months
___ Chemotherapy or Radiotherapy within the last 3 months
___ Herpes simplex (Cold Sores) or fever blisters
___ Diabetes
___ Epilepsy
___ Scars that turn white or brown
___ Dark spots after pregnancy or after skin injury
___ HIV
___ Hepatitis
___ Waxing/Plucking/Electrolysis within last 6 weeks
___ Hirsutism / Polycystic Ovarian Syndrome
___ Transplant Anti-Rejection Drugs
___ Treatment with Accutane® in the last 6 months
___ Chemical Peels, Dermabrasion, Laser Skin Resurfacing or Face Lift
___ Botox and/or Fillers in the treatment area within the last 2 months

Please list any other medications or herbal supplements that you are currently taking:

_____

_____

_____

_____ _____

Client Signature Date