

The Face Company

CLIENT INFORMATION & MEDICAL HISTORY

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

PERSONAL HISTORY

Client Name _____
Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State ____ Zip
Code _____

Home Phone () _____ Work Phone () _____

Emergency Contact Name and
Phone _____

How were you referred to us?

Email _____

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

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 erythematous abigene, 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 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 Others:

MEDICATIONS

What oral 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?

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 (check all that apply)?

- 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 Hyper-pigmentation (darkening of the skin) or Hypo-pigmentation (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 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 for the provider to execute appropriate treatment procedures.

Client/Guardian Signature _____ Date _____

