Lakewood Beauty Clinic

CLIENT INFORMATION AND MEDICAL HISTORY

IN ORDER TO PROVIDE YOU WITH THE MOST APPROPRIATE, SAFE TREATMENT FOR YOU, 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_____

E-Mail
_____

Home Address_____ City_____ State_____ Zip_____

Pharmacy Name and Location_____
Emergency Contact Name and Phone_____
How were your referred to us?
_____

Have you had a previous treatment with Botox, Dysport, or Xeomin? O YES O NO How long ago?

____

Have you had a previous treatment with a dermal filler? O YES O NO How long ago??

_____

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

1 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 African American skin

MEDICAL HISTORY

Are you currently under the care of a physician? O YES O NO
If yes, for what:

_____

_____

Are you currently under the care of a dermatologist? O YES O NO
If yes, for what:

_____

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? O YES O NO
Do you have any of the following medical conditions? (Please check all that apply)

O Cancer O Diabetes O High Blood Pressure O Herpes O Arthritis O Frequent Cold Sores
O HIV/AIDS O Keloid Scarring O Skin Disease/Skin Lesions O Seizure Disorder O Hepatitis
O Hormone Imbalance O Thyroid Imbalance O Blood Clotting Abnormalities
O Any Active Skin Infection
Do you have any other health problems or medical conditions? Please list:

_____

_____

Do you have metal implant, pace maker, or metal piercings? O YES O NO
If yes, what?

_____

Do you have a history of Neuromuscular Disorders? (Please check all that apply)

O Amyotrophic Lateral Sclerosis (LAS) O Multiple Sclerosis O Muscular Dystrophy
O Myasthenia Gravis O Spinal Muscular Atrophy O Bell's Palsy
Any known allergies?_____

Have you ever had an allergic reaction? (Please check all that apply and describe the reaction you experienced)

O Food O Animal Protein O Albumin (Eggs) products O Aspirin O Lidocaine
O Hydrocortisone O Hydroquinone or Skin Bleaching Agents O Others:

SKIN CARE

When was your last facial? What did you have done?

Do you use SPF? When did you last exfoliate?

Describe skin and list main concerns

MEDICATIONS

What oral medications are you presently taking? O Birth Control Pills O Hormones O Other:

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

Have you ever used Accutane or any other acne medications? O YES O NO If yes, when and what did you use last?

What topical medications or creams are you currently using? O Retin-A O Others (Please list):

What herbal supplements do you use regularly?

Are you currently taking an antibiotic? If yes, please list:

Do you take any medications for heart conditions? If so, please list:

Are you taking anticoagulants or medications to thin your blood (i.e. Plavix, Coumadin Aspirin, Baby Aspirin) O YES ONO If yes, please list:

Do you smoke? O YES O NO If yes, how many packs per day/week?

Do you drink alcohol? O YES O NO If yes, how much and how often?

_____

HISTORY

Have you ever had laser hair removal? O YES O NO

Have you used any of the following hair removal methods in the past 6 weeks?

O SHAVING OWAXING O ELECTROLYSIS O TWEEZING OSTRINGING O DEPILATORIES

Have you had any recent tanning or sun exposure that changed the color of your skin? O YES O NO

Have you recently used any self-tanning lotions or had a spray tan? O YES O NO

Do you form thick or raised scars from cuts or burns? O YES O NO

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? O YES O NO If yes, please describe:

_____

PHOTOGRAPHY CONSENT

I authorize the use of my photographs for print and/or social media use (Facebook, Instagram, etc.)

0 YES O NO

FOR OUR FEMALE CLIENTS ONLY:

Are you pregnant or trying to become pregnant? O YES O NO

Are you breastfeeding? O YES O NO

Are you using contraception? O YES O NO

I certify that the preceding medical, personal and skin history statements are true and correct. I agree to be treated by a student under the supervision of a trainer. I am aware that it is my responsibility to inform the technician, 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 procedures.

Signature: _____ Date: _____