SPA SATURDAY CONFIDENTIAL MEDICAL HISTORY

Name:

Address:	***Phone Numbers:***
Street	*Home:*
City	*Work:*
State, Zip	*Cell/Pgr:*

D.O.B:

How were you referred to our facility?

Doctor(s) Name:

1)
2)
3)

Medication Allergies:

1)
2)
3)

Food Allergies:

1)
2)
3)

Current Medications:

1)
2)
3)
4)
5)
6)
7)
8)
9)
10)

Previous Surgeries:

1)	*Date:*
2)	*Date:*
3)	*Date:*
4)	*Date:*
5)	*Date:*

FEMALE CLIENT MEDICAL HISTORY

	<u>**YES**</u>	<u>**NO**</u>
In Menopause?	______	______
Post Menopause?	______	______
Regular Periods?	______	______
Hormone Imbalance?	______	______
Pregnant?	______	______

Are you currently taking any of the following? (Please check)

Birth Control Pills ______

Hormones ______

GENERAL MEDICAL HISTORY

Do you have any of the following? (Mark yes or no for each)

	YES	NO		YES	NO
Acne	_____	_____	Hearing Aid	_____	_____
Canker Sores	_____	_____	Heart Condition	_____	_____
Cancer	_____	_____	Hemophilia	_____	_____
Cold Sores	_____	_____	Hepatitis/Jaundice		_____
Contact Lenses	_____	_____	HIV	_____	_____
Dermatitis /Eczema	_____	_____	Keloid Scars	_____	_____
Diabetes	_____	_____	Metal in Body	_____	_____
Genital Herpes	_____	_____	Moles	_____	_____
Latex Allergy	_____	_____	Pacemaker	_____	_____
Tattoo	_____	_____	Bleeding Disorder		_____
Shingles	_____	_____	Problems w/ healing		_____

Please rate your skin type based on the following scale and personal experience:

_____Type I	Always burn never tan.
_____Type II	Usually burn, tan less that average (with difficulty).
_____Type III	Sometimes mild burn, tan about average.
_____Type IV	Rarely burn, tan more than average (with ease).

On what areas have you had previous treatments for hair removal?

Have you used or have you had any of the following: ***(please circle)***

Accutane Retin-A Burns Chemical Peel Glycolic Acid	Laser Resurfacing Liposuction Photo-derm Intense Light	Sunburn Pulsed Dye Laser Skin Grafts
on this area:	***on this area:***	***on this area:***
Forehead Eyebrows Eyelids Upper Lip Area Breast Abdomen Legs Feet/Toes	Lips Chin Neck (hair line) Cheeks Chest Back Thighs	Sideburns Underarms Shoulders Arms Hands/Fingers Bikini Line Buttocks

I acknowledge that all the above information contributed by me is true and accurate to the best of my knowledge.

____

Signature **Date**