Confidential Client Health History Form

Date:

Name:

Date Of Birth:

Race (check all that apply):

- [ ] White
- [ ] Black or African American
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander

Other:

Address:

City, State

Zip Code

Home Phone:

Cell Phone:

Email:

Primary Care Provider:

Emergency Contact Name:

Emergency Contact Phone Number

Relationship to Emergency Contact

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?

- ○ Yes
- ○ No

Yes, explain:

2) Any recent surgery, including plastic surgery?

- ○ Yes
- ○ No

Yes, explain:

Have you had any recent dental work?

- ○ Yes
- ○ No

Yes, explain:

3) Any skin cancer?

- ○ Yes
- ○ No

Yes, explain:

4) Have you had any piercings, tattoos, or permanent cosmetics?

- ○ Yes
- ○ No

If yes, where?

8) Do you smoke?

- ○ Yes
- ○ No

If yes, how often?

9) Do you follow a restricted diet?

- ○ Yes
- ○ No

If yes, specify:

Your Health

(Please check all that apply and provide additional information in the space provided)

- ☐ Cancer
- ☐ Headaches (chronic)
- ☐ Hormone imbalance
- ☐ Hepatitis
- ☐ Systemic disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ Frequent cold sores
- ☐ Spinal injury
- ☐ Immune disorders
- ☐ Thyroid condition
- ☐ HIV/AIDS
- ☐ Hysterectomy
- ☐ Lupus
- ☐ Diabetes
- ☐ Metal bone pins or plates
- ☐ Heart problem
- ☐ Phlebitis, blood clots, poor circulation

- [ ] Blood clotting abnormalities
- [ ] Arthritis
- [ ] Psychological treatment
- [ ] Asthma
- [ ] Insomnia
- [ ] Eczema
- [ ] Keloid scarring
- [ ] Epilepsy
- [ ] Skin disease/skin lesions
- [ ] Seizure disorder
- [ ] Any active infection
- [ ] Fever blisters
- [ ] Increased light sensitivity
- [ ] Heart Disease
- [ ] Stroke
- [ ] None

Confidential Client Health History Form—continued

10) Do you follow a regular exercise program?

- ○ Yes
- ○ No

11) What is your stress level?

- ☐ High
- ☐ Medium
- ☐ Low

List any medications you take regularly:

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products?

- ○ Yes
- ○ No

Yes, Describe:

13) Do you form thick or raised scars from cuts or burns?

- ○ Yes
- ○ No

14) Have you used an acne medication?

- ○ Yes
- ○ No

Yes, when?

Which drug?

15) Have you used any of these products in the last 3 months?

- Yes
- No

16) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?

- Yes
- No

Yes,describe:

List your daily consumption of:

Water

Caffeine

Alcohol

18) How many hours do you typically sleep each night?

17) Do you experience any problems sleeping?

- Yes
- No

18) Have you been exposed to the sun or used a tanning bed in the last 48 hours?

- Yes
- No

19) How frequently are you exposed to the sun or use a tanning bed?

- Infrequently
- Frequently
- Regularly

Confidential Client Health History Form—continued

20) Do you have any metal implants or wear a pacemaker?

- ○ Yes
- ○ No

21) Have you ever experienced claustrophobia?

- ○ Yes
- ○ No

22) Do you suffer from sinus problems?

- ○ Yes
- ○ No

23) Have you ever had an adverse reaction after using any skin care product? (Please check any that apply)

- ☐ Rash
- ☐ Irritation
- ☐ Peeling
- ☐ Sun Sensitivity
- ☐ Breakout
- ☐ None

24) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)

- [ ] Cosmetics
- [ ] Medicine
- [ ] Food
- [ ] Animals
- [ ] Sunscreens
- [ ] Iodine
- [ ] Pollen
- [ ] AHAs
- [ ] Fragrance
- [ ] Shellfish
- [ ] Latex
- [ ] Drugs
- [ ] Other:
- [ ] None

If yes, please explain:

Female Clients Only:

25) Are you taking oral contraceptives?

- ○ Yes
- ○ No

Yes, specify:

26) Any recent changes to or from your contraceptive treatment?

- ○ Yes
- ○ No

Yes, If so, what and when?

27) Are you pregnant or trying to become pregnant?

- ○ Yes
- ○ No

28) Are you lactating?

- ○ Yes
- ○ No

29) Any menopause problems?

- ○ Yes
- ○ No

Yes, specify:

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Date

09/21/2025

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

Client Signature

Tap here to sign