CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate hair removal or skin care treatment, we would appreciate your completing the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Name______________________________ Date______________

Date of Birth______________ Age_____ Occupation ______________

Address ______________________________

City__________________ State________ Zip __________

Home Phone__________________ Work Phone__________________

Email Address ______________________________

Emergency Contact Name and Phone ______________________________

How were you referred to us? ______________________________

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

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

MEDICAL HISTORY

Are you currently under the care of a physician? [ ] YES [ ] NO

Are you currently under the care of a dermatologist? [ ] 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/lesions
[ ] Seizure disorder | [ ] Hepatitis/Liver Disease | [ ] Hormone imbalance
[ ] Thyroid imbalance | [ ] Blood clotting abnormalities | [ ] Any active infection

Do you have any other health problems or medical conditions? If yes, please list:__________________

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What oral medications are you presently taking? (Please check all that apply.)

[ ] Accutane [ ] Birth control pill [ ] Hormones
[ ] Other: ____________________

- OVER -

Have you ever used Accutane? [ ] YES [ ] NO If yes, when did you last use it? ______________________

What topical medications and/or creams are you currently using? (Please check all that apply.)

[ ] Retin-A [ ] Others:______________________

Have you ever had laser hair removal? [ ] YES [ ] NO

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

[ ] 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:______________________

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

[ ] Food [ ] Latex [ ] Cosmetics [ ] Aspirin
[ ] Lidocaine [ ] Hydrocortisone [ ] Hydroquinone or skin bleaching agents
[ ] Other

Reaction:______________________

FOR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? [ ] YES [ ] NO
Are you using contraception? [ ] YES [ ] NO
Are you breast feeding? [ ] YES [ ] NO

CLINIC POLICIES

* I understand that there will be no refunds for any treatment, product, services or gift certificates.
* I understand that if I fail to provide 24-hour notice of cancellation, I will be billed for the service as scheduled.
* I understand that treatments are not covered by insurance and that payment is due at the time service is rendered.
* I understand that this signed consent form shall remain effective through my continuity of care on behalf of Allure Medical. This is in regard to the treatment that I shall receive today and any future treatments or services rendered to me by Allure Medical.

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, aesthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

______________________ ______________________

Printed Name Date

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Signature