

CONFIDENTIAL HEALTH HISTORY

Name: _____ Date Of Birth: _____

Address: _____

Preferred Phone: _____ Secondary Phone: _____


Email: _____ Occupation: _____

Referred by: ☐ Friend _____ ☐ Walk by ☐ Internet search ☐ Social media
☐ Other _____














All information provided is voluntary. It will be kept confidential and secure. This information is used to determine contraindications to treatment, factors that can impact skin health and to provide customized skin health program recommendations.


Health

 List any medications that you take regularly: _____

 **Female Clients Only**
Are you taking oral contraceptives? ☐ No ☐ Yes Are you pregnant or trying to become pregnant? ☐ No ☐ Yes
Are you in perimenopause/menopause? ☐ No ☐ Yes Symptoms? _____



Do you have any of these health conditions? Please check all that apply.  =MD permission for treatment



	Injuries: _____		Arthritis
	Cancer (chemotherapy/radiation)		High blood pressure
	Liver or kidney problems		Thyroid condition
	Frequent cold sores		Metal pins or plates
	Autoimmune disease		Diabetes/prediabetes
	Skin disease, lesions, or warts		PCOS/ovarian cysts
	Any active infection		Varicose veins
	Epilepsy/seizures		Fibromyalgia/CFS
	Phlebitis, blood clots, poor circulation		Asthma/allergies
	Heart problems		Glaucoma



 Have you ever had an allergic reaction to the following? Please check all that apply.





☐ Cosmetics ☐ Food ☐ Animals ☐ Sunscreens ☐ Iodine
☐ Pollen ☐ Alpha hydroxy acids ☐ Fragrance ☐ Shellfish ☐ Latex

Lifestyle

Diet  **How many days a week do you consume:** Processed foods _____ Broiled/grilled foods _____ Baked goods _____
Fruits _____ Vegetables _____ Vitamin D3 _____ Fish oil supplement _____ Multivitamin _____ Other Supplements _____
 **How many days a week do you consume:** Caffeine _____ Alcohol _____ Soft Drinks _____ How much? _____
About how much water do you drink daily? _____

Activity  **Do you follow a regular exercise program?** ☐ No ☐ Yes **How many days a week?** _____
 **Are your leisure activities:** ☐ Sedentary ☐ Active ☐ Good balance of rest and activity

Stress  **Do you smoke?** ☐ No ☐ Yes **What is your stress level?** ☐ High ☐ Medium ☐ Low
 **Do you experience problems sleeping?** ☐ No ☐ Yes **Type of problems:** _____

Sun  **Have you used a tanning bed in the last 48 hours?** ☐ No ☐ Yes
 **How frequently are you exposed to the sun or use a tanning bed?** ☐ Infrequently ☐ Frequently ☐ Regularly
 **How many sunburns have you had before age 21?** _____ **After age 21?** _____
 **Does your job require you to work outdoors or drive often?** ☐ No ☐ Yes

Do you wear contact lenses? ☐ No ☐ Yes **Do you wear glasses?** ☐ No ☐ Yes

Skin Care History: Medical

Do you use any topical products prescribed by a medical professional? ☐ No ☐ Yes


Products: _____



Do you use any products prescribed by a medical professional for acne or rosacea? ☐ No ☐ Yes

Products: _____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes Details: _____

Any injectable cosmetic procedures (e.g. Botox, Restylane)? ☐ No ☐ Yes Details: _____

  Do you form thick or raised scars (keloid scars) from cuts, burns or other physical trauma? ☐ No ☐ Yes

  Do you get discoloration or redness in your skin after healing from physical trauma? ☐ No ☐ Yes

Skin Care History: Cosmetics & Treatments Used












Have you ever had an adverse reaction to any skin care product, waxing, lash extension, body or facial treatment?

☐ No ☐ Yes

Please check all that apply, and name the product or treatment that caused it.

☐ Rash ☐ Irritation ☐ Peeling ☐ Sun Sensitivity ☐ Breakout ☐ Other _____

What skin care products are you currently using? (Specify what skin type they are designed for, if known.)

 	 AM: Cleanser/Toner	
	Moisturizer/SPF/Eye Cream	
	Makeup	
	Other	
 	 PM: Cleanser/Toner	
 	Serum/Eye Cream/Night Cream	
	Other	
 	WEEKLY: Prescriptions/Scrubs/Masks	
	PROFESSIONAL: Face/body treatments, waxing, peels etc that you visit a professional to receive regularly	

Have you used any of the following hair removal methods in the past 2 weeks? Please check all that apply.

☐ Shaving/Dermaplaning

☐ Waxing/Sugaring

☐ Electrolysis

☐ Tweezing

☐ Threading

☐ Depilatories (Cream)

Future Appointments/Contact

May I contact you by phone to confirm future appointments? ☐ No ☐ Yes Text Message? ☐ No ☐ Yes

May I contact you by email about future promotions and news? ☐ No ☐ Yes

May I give you professional home care recommendations and a treatment plan to address your needs? ☐ No ☐ Yes

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 withholding information or providing misinformation may result in adverse skin reactions from treatments or products received. I am aware that it is my responsibility to inform the skin care professional of my current medical or health conditions, and to update this history when necessary. I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Name: _____

Date: _____

Client Signature: _____

Esthetician: _____