DERMACENTER
MEDICAL SPA
medical spa | skin care services

CLIENT INFORMATION AND MEDICAL HISTORY

PERSONAL INFORMATION

NAME: ______________________________ TODAY'S DATE: ____________________

DATE OF BIRTH: ____________ AGE: ________ OCCUPATION: ________________________

HOME ADDRESS: __________________ CITY: ____________ STATE: _____ ZIP CODE: ________

PHONE #: __________________ EMAIL: ______________________________

EMERGENCY CONTACT NAME AND PHONE: ______________________________

HOW WERE YOUR REFERRED TO US? ______________________________

WHAT TREATMENTS ARE YOU INTERESTED IN? *Please check those that apply*

- ☐ Laser Hair Removal
- ☐ Skin Rejuvenation
- ☐ Cellulite Reduction
- ☐ Medical Grade Products
- ☐ Vein Removal
- ☐ Skin Tightening
- ☐ Chemical Peel
- ☐ Microdermabrasion
- ☐ Juvéderm/Fillers
- ☐ Skin Analysis
- ☐ BOTOX® Cosmetic

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE? *Please check the appropriate box or boxes*

- ☐ Always burns, never tans (1)
- ☐ Sometimes burns, always tans (3)
- ☐ Brown skin (5)
- ☐ Always burns, sometimes tans (2)
- ☐ Rarely burns, always tans (4)
- ☐ Black skin (6)

HAVE YOU EVER HAD LASER HAIR REMOVAL? ☐ Yes ☐ No

HAVE YOU USED ANY OF THE FOLLOWING HAIR REMOVAL METHODS IN THE PAST SIX WEEKS? *Please check those that apply*

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking/Tweezing ☐ Stringing ☐ Depilatories

HAVE YOU HAD A DEEP CHEMICAL PEEL IN THE LAST THREE MONTHS? ☐ Yes ☐ No

HAVE YOU HAD ANY RECENT TANNING/SUN EXPOSURE THAT CHANGED YOUR SKIN COLOR? ☐ Yes ☐ No

HAVE YOU RECENTLY USED ANY SELF-TANNING LOTIONS OR TREATMENTS? ☐ Yes ☐ No

ARE YOU CURRENTLY USING ANY MEDICAL-GRADE SKIN-CARE PRODUCTS? ☐ Yes ☐ No

IF YES, PLEASE LIST: ______________________________

DO YOU FORM THICK OR RAISED SCARS FROM CUTS OR BURNS? ☐ Yes ☐ No

DO YOU HAVE HYPER- OR HYPO-PIGMENTATION (DARKENING OR LIGHTENING OF THE SKIN) OR MARKS AFTER PHYSICAL TRAUMA? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE: ______________________________

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MEDICAL HISTORY

ARE YOU PREGNANT OR NURSING? ☐ Yes ☐ No

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING? *Please check all that apply*
☐ Food ☐ Latex ☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone
☐ Hydroquinone or skin bleaching agents ☐ Other: ______________________

DESCRIPTION OF REACTION (IF ANY): ______________________

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THESE MEDICAL CONDITIONS? *Please check all that apply*
☐ Tattoo or permanent makeup ☐ Impaired immune system ☐ Cancer
☐ Pacemaker/defibrillator ☐ Frequent cold sores ☐ Hepatitis
☐ Blood clotting abnormalities ☐ Keloid scarring ☐ Arthritis
☐ Hormone Imbalance ☐ Thyroid imbalance ☐ Any active skin infection or herpes
☐ Facial laser resurfacing ☐ Cardiac disorders ☐ Endocrine disorders (i.e. diabetes, PCO
☐ High Blood Pressure ☐ Varicose veins
☐ Hepatitis ☐ Dermal Fillers such as Juvéderm or Restylane
☐ HIV/AIDS ☐ Skin disease/skin Lesions (i.e. psoriasis, eczema, sores, rashes)
☐ Metal implant(s) ☐ Light-stimulated disease (i.e. lupus, epilepsy, porphyria)

DO YOU HAVE ANY OTHER HEALTH PROBLEMS OR MEDICAL CONDITIONS? IF SO, PLEASE LIST: ______________________

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WHAT ORAL MEDICATIONS ARE YOU PRESENTLY TAKING?
☐ Birth control pills ☐ Hormones ☐ Antibiotics ☐ Others (Please list): ______________________

ARE YOU ON ANY MOOD ALTERING OR ANTI-DEPRESSION MEDICATION? ☐ Yes ☐ No

IF YES PLEASE LIST: ______________________

HAVE YOU EVER USED ACCUTANE OR OTHER MEDICATIONS OR HERBS INDUCING PHOTOSENSITIVITY? ☐ Yes ☐ No

IF YES, WHAT WAS THE PRODUCT AND WHEN DID YOU USE IT? ______________________

WHAT TOPICAL MEDICATIONS, CREAMS OR HERBS ARE YOU CURRENTLY USING?
☐ RetinA ☐ Others (Please List): ______________________

I certify that the preceding medical, personal and skin history statements are true and accurate. I am aware that it is my responsibility to inform the technician, esthetician, 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.

Client/Guardian Signature: ______________________ Date: ______________________

Reviewed By: ______________________ Date: ______________________