



Client Information/Medical History

Name: _____ **Date:** _____

Please answer the following questions. They are necessary for our records and the safety of your treatments.

List all medications you are taking at the present time including over-the-counter, topicals, and especially those that are prescribed for Skin ailments i.e. Rosacea and Acne.

Are you allergic to any medications or Latex? _____
If so please list: _____

Are you presently using any of the following products/medications?

Retin-A/Renova (Tretinoin) _____

Birth control _____

Steroids (such as Prednisone) _____

Accutane _____

Any blood thinning med including daily aspirin _____

Do you have any of the following conditions?

Pregnancy or breast-feeding _____

Polycystic Ovary Syndrom (PCOS) _____

Herpes (cold sores) _____

Keloid (raised) scarring _____

Diabetes _____

Connective tissue disease (Lupus, Rheumatoid Arthritis) _____

Any neurological disorder _____

Any active infection or MRSA _____

Planning on having any type of eye procedure
done soon i. e. LASIK? _____

**Have you had any unprotected sun exposure, recently tanned,
used tanning creams, or are you planning on tanning soon?** _____

Do you any permanent makeup, implants, or tattoos
that are in the area of desired treatment? _____

Is your skin Oily _____ Dry _____ Combination _____

What is your current skin care regimen? _____
