Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ☐Food ☐Latex ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Hydroquinone or skin bleaching agents ☐Others:_____

_____

MEDICATIONS

What oral medications are you presently taking? ☐Birth control pills ☐Hormones

☐Others (Please list): _____

Are you on any mood altering or anti-depression medication?_____

Have you ever used Accutane? ☐Yes ☐No, If yes, when did you last use it?_____

What topical medications or creams are you currently using? ☐ Retin-A® ☐Others (Please list):

_____

What herbal supplements do you use regularly?_____

HISTORY

Have you ever had laser hair removal? ☐Yes ☐No

Have you used any of the following hair removal methods in the past six 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 Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐Yes ☐No If yes, please describe: _____

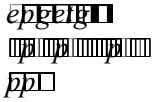
_____

For our female clients:

Are you pregnant or trying to become pregnant? ☐Yes ☐No Are you breastfeeding? ☐Yes ☐No

Are you using contraception? ☐Yes ☐No

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, 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.



Signature_____ Date:_____