

**Spa and Esthetics Clinic Health History**

Prior to receiving treatment, we require an accurate health history to assist us in treating you safely. If your health status changes in the future please inform the treatment provider.

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: MONTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAY \_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What do you hope to accomplish during your treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you rate your overall health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had surgery in the past 12 months? Yes \_\_\_\_\_ No\_\_\_\_\_

Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ❏ HIV |  | |  | ❏ Anxiety/Mental Health Issue | | |
|  |  | ❏ Hepatitis |  | |  | ❏ Warts | | |
|  |  | ❏ Cancer |  | |  | ❏ Arthritis | | |
|  |  | ❏ Diabetes |  |  | ❏ Asthma | |  |
|  |  | ❏ TB |  |  | ❏ Shortness of Breath | |  |
|  |  | ❏ Heart Condition |  |  | ❏ Emphysema | |  |
|  |  | ❏ Chronic Congestive Heart Failure |  |  | ❏ Bronchitis | |  |
|  |  | ❏ Thyroid |  |  | ❏ Chronic Cough | |  |
|  |  | ❏ Heart Disease |  |  | ❏ Phlebitis/Varicose Veins | |  |
|  |  | ❏ Pace Maker of Similar Device |  |  | ❏ Hysterectomy | |  |
|  |  | ❏ Hypersensitivity |  |  | ❏ Eczema | |  |
|  |  | ❏ Stroke |  |  | ❏ Psoriasis | |  |
|  |  | ❏ High Blood Pressure |  |  | ❏ Skin Conditions | |  |
|  |  | ❏ Low Blood Pressure |  |  | ❏ Fungus | |  |
|  |  | ❏ Herpes |  |  | ❏ Corns | |  |
|  |  | ❏ Infectious Disease |  |  | ❏ Ingrown Toenails | |  |
|  |  | ❏ Epilepsy |  |  | ❏ Other | |  |

Over

Additional comments and/or concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all medications you are currently taking and the condition it treats: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an allergic reaction to a product applied to your skin? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which products or ingredients? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your skin and your present skin care regime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What skin care product line are you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you like it? Yes \_\_\_\_\_ No\_\_\_\_\_

Do you have a specific skin condition do you wish to correct? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you tan in a tanning bed? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use tobacco products? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what products and how frequently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Accutane, Retinol, Tretinoin or Prescription Vitamin A on your skin? Yes \_\_\_\_\_ No\_\_\_\_\_

Please list sensitivities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a dermatologist? Yes \_\_\_\_\_ No\_\_\_\_\_

Do you have any internal pins, wires, artificial joints or metal implants? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, where are they located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on any type of hormone therapy? Yes \_\_\_\_\_ No\_\_\_\_\_

Do you wear contact lenses? Yes \_\_\_\_\_ No\_\_\_\_\_

Women only: Are you pregnant or trying to become pregnant? Yes \_\_\_\_\_ No\_\_\_\_\_ If yes to being pregnant, when is your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the information above is true and correct. I understand that it is my responsibility to inform the Esthetic Student and Staff of my current medical or health concerns, which are essential for proper treatment. My signature below constitutes my consent to treatment. I hereby give my consent and authorization voluntarily and release this establishment and its agents of any claims that I have or may have in the future connection with the treatment.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT)

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT)



Admin Use only: Medical History Updates

|  |  |  |  |
| --- | --- | --- | --- |
| Date (DD/MM/YY) | Changes or No Significant Findings (NSF) | Student | Staff |
|  |  |  |  |
|  |  |  |  |