Medical History Form

Name: _____ Date:_____
Last First

Address: _____ City: _____ST:_____ Zip:_____

Email: _____ Phone: _____

Emergency Contact Name and Phone _____
How did you hear about Skin Renew Day Spa? _____

Which of the following best describes your skin type?

☐ Always burns, never tans (I) ☐ Always burns, sometimes tans (II) ☐ Sometimes burns, tans gradually (III)
☐ Rarely burns, tans easily (IV) ☐ Skin darkens, never burns (V) ☐ Very dark skin (VI)

How old is your tattoo? _____Is it homemade or professional?_____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what:_____
Are you currently under the care of a dermatologist? ☐ Yes ☐No If yes, for what:_____
Have you ever had a reaction to a laser/heat treatment or radiation therapy? ☐No / ☐If yes, when:_____
Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer ☐ Diabetes ☐ Herpes ☐ Arthritis ☐ Frequent cold sores ☐ HIV/AIDS
☐ Keloid scarring ☐ Skin disease/Skin lesions ☐ Seizure disorder ☐ Hepatitis
☐ Blood clotting abnormalities ☐ Any active infection ☐ Migraine headaches ☐ Heart disease
☐ Autoimmune disease ☐ Poor Circulation ☐ Skin cancer (location/type):_____

Do you have any other health problems or medical conditions? ☐ Yes ☐ No
Please list: _____

MEDICATIONS

It is very important for you to list ALL medications you are taking. Certain medications, such as light-sensitive medications, can have serious interactions with the laser.

What oral or topical medications are you presently using?
Please list: _____
_____
_____
_____
_____
_____

Have you ever used Accutane or Retin-A©? ☐ Yes ☐ No
If yes, when did you last use it? _____

Have you ever had an allergic reaction to any medications? ☐ Yes ☐ No
If yes, please list_____

Have you recently taken antibiotics? ☐ Yes ☐ No
If yes, please list antibiotic and reason for use_____

HISTORY

Do you currently have a sunburn? ☐ Yes ☐ No
Do you currently have a tan? ☐ Yes ☐ No
Do you form thick or raised scars from cuts or burns?_____

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_____

Have you had any previous laser or IPL treatments of any kind? ☐ Yes ☐ No
If yes, did you have any problems (pigmentation issues, blisters, burns) ☐ Yes ☐ No
If yes, please describe_____

FOR FEMALE CLIENTS ONLY
Are you pregnant or trying to become pregnant? ☐ 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, doctor or nurse of my current medical or health conditions and to update this history at each visit. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature_____ Date _____