

HEALTH HISTORY ASSESSMENT

Please print clearly.

Name: _____

Address: _____ Phone Bus: _____

Phone Res: _____ Cell Phone: _____

Date of Birth: _____ Postal Code: _____

Referred by: _____ Occupation: _____

1. How did you find us? Yellow Pages Website Magazine ad

Other _____

2. Do you have any allergies? (eg.: medications, food, other)

Please describe: _____

3. Are you currently taking any medications? Please specify. _____

4. Have you ever consulted a physician regarding excessive hair growth? yes no

5. Please check applicable:

MALES AND FEMALES

Dysplastic Nevi	yes <input type="checkbox"/> no <input type="checkbox"/>
Keloid scarring	yes <input type="checkbox"/> no <input type="checkbox"/>
Accutane taken in last 12 months	yes <input type="checkbox"/> no <input type="checkbox"/>
Previous diagnosis of vitiligo	yes <input type="checkbox"/> no <input type="checkbox"/>
History of cold sores	yes <input type="checkbox"/> no <input type="checkbox"/>

FEMALES ONLY

Hormonal imbalance	yes <input type="checkbox"/> no <input type="checkbox"/>
Elevated testosterone	yes <input type="checkbox"/> no <input type="checkbox"/>
Normal Menstrual Cycle	yes <input type="checkbox"/> no <input type="checkbox"/>
Menarche (age) _____ yrs.	yes <input type="checkbox"/> no <input type="checkbox"/>
Pregnant	yes <input type="checkbox"/> no <input type="checkbox"/>
Infertile	yes <input type="checkbox"/> no <input type="checkbox"/>
Post-menopausal	yes <input type="checkbox"/> no <input type="checkbox"/>
Estrogen therapy	yes <input type="checkbox"/> no <input type="checkbox"/>

6. Have you had laser resurfacing within the last 3 months? yes no

7. Have you had mechanical or chemical peeling within the last 4 weeks? yes no

8a. Have you done any tanning within the last 4 weeks? yes no

8b. Have you used liquid tan product? yes no

9. Please check most applicable to indicate your skin type:

- Type 1 -always burn, never tan (extremely fair skin/blonde hair/blue/green eyes)
- Type 2 -always burn, sometimes tan (fair skin sandy to brown hair, green/blue eyes)
- Type 3 -sometimes burn, tan somewhat (medium skin, brown hair, green/brown eyes)
- Type 4 -rarely burn, tan with ease (olive skin, brown/black hair, brown/black eyes)
- Type 5 -moderately pigmented, tan profusely (dark brown skin, black hair, black eyes)
- Type 6 -deeply pigmented, never burn (black skin, black hair, black eyes)

10. Please check or answer:

Scalp hair: colour _____ curly ___ straight ___ wavy ___ Eye colour: _____ Ethnicity: _____

11. Check areas you wish to have treated:

FACIAL/HEAD AREAS

- Lip (over) *
- Lip (under) *
- Chin *
- Neck *
- Sideburns *
- Cheeks *
- Eyebrows
- Glabella
- Nose
- Ears
- Hairline (frontal)
- Nape

Other _____

BODY AREAS

- Sternum *
- Breasts *
- Abdomen *
- Arms *
- Back
- Spine *
- Buttocks *
- Underarms
- Bikini
- Thighs
- Legs
- Chest
- Shoulders

Other _____

12a. If hair growth is present in females in areas noted above with *, was onset sudden ___ or gradual ___ ?

12b. Hair first became apparent due to: Age ___ Pregnancy ___ Menopause ___ Oral contraceptives ___
Hormone treatments ___ Dilantin ___ Streptomycin ___ Other _____

13. Please check to indicate hair removal methods you have used:

- Electrolysis
- Bleaching
- Laser
- Tweezing
- Shaving
- Waxing
- Chemical depilation
- Threading

If tweezing, waxing, or threading has been used:

Area _____ Date last used _____ Complications _____

Area _____ Date last used _____ Complications _____

Area _____ Date last used _____ Complications _____

14. For previous electrolysis treatments:

Date of first treatment _____ Date of last treatment _____
Was previous treatment successful? yes ___ no ___ Reason for discontinuing treatment? _____

15. Check any of the following conditions or treatments you may have had:

- Bleeding problems
- Hemophilia
- Circulatory problems
- Diabetes
- Asthma
- Epilepsy
- High blood pressure
- Heart disease
- Pacemaker
- Ovarian Disorder
- Cancer
- Hodgkin's disease
- Chemo/radiation
- Tuberculosis
- Thyroid problems
- Herpes I (cold sores) or II
- STD
- Hepatitis (type? ___)
- HIV Positive

16. Have you ever used Retin A? yes ___ no ___

17. Have you had Collagen injections? yes ___ no ___ Verify date of last injection before each treatment.

18. Are you currently under the care of a physician or other health care provider?

Reason _____

I understand that health history information is important to the technician so as to provide me with safe and effective laser/electrology treatments. I agree to update this form whenever there are changes.

Patient Signature (or Parent/Guardian) _____

Witness to signature: _____ Date: _____