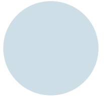
Client Health History: Radio Frequency/High Frequency Treatment of Skin Irregularities Health History Intake



Name: ____Date of Birth: _________________

Address:______________________________City:____________________State:_______Zip: ______

Home/Cell Phone:____________________________Work: ________________________________

Email:_____________________________________ Preferred Contact: Cell___ Work ___ Email ___

Emergency contact name: _______________________________ Phone: _____________________

Relationship to you: ____

Are you over the age of 18 years? Yes___ No___

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

❏ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common

❏ II. Fair skinned; light hair, light eyes

❏ III. Very common skin type; fair; eye and hair color vary

❏ IV. Mediterranean Caucasian skin; medium to heavy pigmentation

❏ V. Mideastern skin; rarely sun sensitive

❏ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❏ Yes ❏ No

Cosmetic History

How would you describe your skin? Normal___ Combination___ Oily___ Dry____

When were you last exposed to the sun (including tanning beds)? ______________________________

Have you ever had treatments for vascular veins, pigmented lesions, or other unwanted lesions? Yes ___ No___

If yes, when? ___________ What body area(s) were treated?__________________________

Describe your experience____

Have you used Accutane in the past year? Yes____ No____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation?

Please List:____

Have you ever had any of the following injectables or implants?

Botox	Radiesse	Perlane	Collagen	Dysport
Juvederm	Restylane	Silicone	Sculptra	

Other: ____

If yes, when? ___________ What body area(s)? ______________________________________

Continued ⇨

Health History

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 ____

____

Do you form thick or raised scars from cuts or burns? Yes___ No___

Have you had chemotherapy in the past 6 months? Yes___ No_____

Do you have any allergies to medications, food, latex, topical products, and/or other substances? ___________

____

Do you have any of the following conditions?

___Epilepsy ___Pregnancy and/or breastfeeding ___Autoimmune disease ___Herpes Simplex ___Diabetes

___Dental implants, crowns, metal fillings ___Pacemaker or internal defibrillator

___Implanted neuro stimulators or other internal electric device

___Metal implants or other implants in the treatment area, i.e. IUD, screws, plates ___Varicose veins

___History of skin disorders

Do you have a history of Erythema Ab Igne (EAI), a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? Yes ___ No ___

Do you have any other health condition not mentioned here? Yes___ No___

If yes, please list ____

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Have you undergone any recent surgery? Yes___ No___ I

f yes, please explain ____

Please list all vitamins and supplements including herbal remedies you take regularly ______________________

____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly __________

____

Is there anything else you would like us to know? ____

____

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 esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) ____

Client Name (Signature) ____ Date: _________

Esthetician/Technician: ____ Date: _________