Age Graceful

# Client Medical History | Intake Form

Last Name: ______________________________ First Name:______________________________

Do you go by any other names?______________________________

Address:______________________________________________________

City:______________________________ State:________ Zip Code:________________

Email Address______________________________________________________

Date of Birth:_________________________ Sex:_______

Telephone: Home:___________________ Cell:______________________________

May we contact or leave a confidential message at the above number? Y or N

Emergency Contact:______________________________ Phone:______________________________

1. Which area/areas or condition would you like treated?
   ________________________________________________________________________________

_

2. Have you had skin care treatments in the past? Y or N
3. It may be necessary to change your current regimen for optimum results, is this okay? Y or N
4. Do you usually break out after skin care treatments? Y or N
5. Have you ever had an adverse reaction after using any skin care product? Y or N
6. Have you ever experienced unexplained itching, swelling, flaking, or redness after a facial? Y or N
7. Do you use a sunblock daily? Y or N
8. Do you suffer from hyper(more) or hypo(less) pigmentation? Y or N
9. Is there anything that we should know about you that we have not asked of that may better service you?

________________________________________________________________________________

10. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List:____________________________________________________
11. What is your current home care regimen?
    - ☐ Cleanser _____________________
    - ☐ Exfoliant/Scrub _____________________
    - ☐ Toner _____________________
    - ☐ Mask _____________________
    - ☐ Day Moisturizer _____________________
    - ☐ Night Moisturizer _____________________
    - ☐ Serum/Concentrate _____________________

©2022 Age Graceful LLC, all rights reserved for Age Graceful

________Client Initials

- ☐ Sunblock ____________________
- ☐ Other ____________________

**Please answer all of the following questions**

- Do you have **ANY** current or chronic medical illnesses? Y or N

☐ Heat urticaria
☐ Diabetes
☐ Autoimmune disorder or any immunosuppression
☐ Blood disorder
☐ Cancer
☐ Bacterial or viral infections
☐ Medical conditions that significantly compromise the healing response
☐ Skin photosensitivity disorder
☐ Or any other condition or illness

Please Explain:
__________________________________________________________________________________________

_

- Do you have **ANY** current or chronic skin conditions?
  - ☐ Vitiligo
  - ☐ Eczema
  - ☐ Melasma
  - ☐ Psoriasis
  - ☐ Allergic dermatitis
  - ☐ Any diseases affecting collagen, including Ehlers-Danlos syndrome
  - ☐ Scleroderma
  - ☐ Skin Cancer
  - ☐ Any other skin condition

Please Explain:
__________________________________________________________________________________________

_

- Are you currently under a doctor's care or have you been in the last year?
  Y or N
  If yes, please explain:
__________________________________________________________________________________________

_

- Have you had any recent surgeries (including plastic surgery) in the past year? Y or N

©2022 Age Graceful LLC, all rights reserved for Age Graceful

- Have you used any type of medication for acne conditions? Y or N
- Have you taken Accutane (or products containing isotretinoin) in the last 12 months? Y or N
- Have you used Tretinoin (like Retin-A, Renova) in the last 6 months? Y or N
- Do you smoke? Y or N
- Do you wear contact lenses or glasses? Y or N
- Have you ever had an allergic reaction to any of the following? **Please Circle all that apply**

| | | | |
|---|---|---|---|
| Cosmetics | Medicine | Food | Animals |
| Sunscreens | Iodine | AHA | Fragrance |
| Shellfish | Latex | Drugs | Pollen |
| Other | None | | |

- List all prescription and over the counter medications, herbs, or vitamins you take on a regular basis. ________________________________________________________________________
  ____________________________________________________________________________________

_

- Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? Y or N
- Are you or could you be pregnant? Y or N or N/A
- Hage you have regular menstrual periods? Y or N or N/A
- Have you ever been diagnosed with Polycystic Ovarian Disorder? Y or N or N/A
- Do you have a history of herpes I or II in the area to be treated? Y or N
- Do you have a history of keloid scarring or hypertrophic scar formation? Y or N
- Do you have a history of light induced seizures? Y or N
- Do you have any open sores or lesions? Y or N
- Do you have any history of radiation therapy? Y or N
- Have you ever had systemic Gold Therapy? Y or N
- In the last (6) six months, have you used any of the following? Y or N
  Anticoagulants Blood-thinning, medications
  Photosensitizing medications Anti-inflammatory
  Please list product name and date last used:
  ________________________________________________________________________
- In the last (3) three months, have you used any of the following products: Y or N
  Glycolic acid
  Other alpha hydroxy or beta hydroxy acid products
  Exfoliating or resurfacing products or treatments?
  Please list product name and date last used:
  ________________________________________________________________________
- Do you have or have you ever had any permanent makeup, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane, etc? Y or N
  If yes, please list location on or in the body and date last used:

©2022 Age Graceful LLC, all rights reserved for Age Graceful

______________________________________________________________________

- Do you have or have you ever had any Botulinus, such as Botox or Dysport? Y or N
  If yes, please list location on or in the body and date last used:
  ______________________________________________________________________
- Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? Y or N
- Do you have any metal implants (pacemaker, surgical implants, pins, etc)? Y or N

I understand that by authorizing below, I hereby voluntarily give my consent and authorization for the procedure I have requested and agree to release Age Graceful LLC, Its owner, employees and/or contractors from any claims or liabilities now or in the future. I, Age Graceful Client, have been advised of the risks involved by written and/or verbal delivery and elect to continue having services performed with my consent. I also agree that by signing this waiver, I will not hold Age Graceful liable if any issues arise as a result thereof.

Client Name ________________________________ Date_________________________

Client Signature ____________________________________________

©2022 Age Graceful LLC, all rights reserved for Age Graceful

________Client Initials