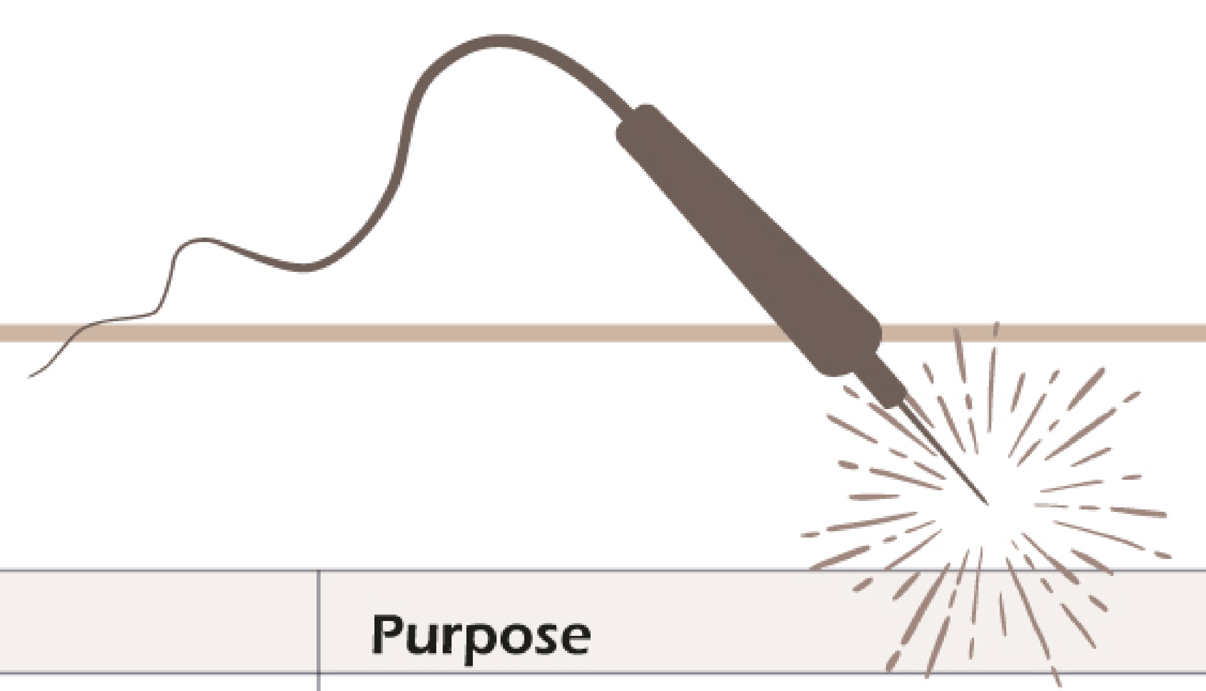
Client Health History Assessment



Health Information

List All Medications & Vitamins You are Currently Taking:

Name	Purpose	Name	Purpose

List All Allergies:

Name	Comments	Name	Comments

Health Conditions Present or Past: {circle all that apply}

Acne Body Piercings Beathing Problems Cancer Cardiovascular Disease Clotting Issues Cold Sores COPD Diabetes Dizziness / Fainting Heart Attack Healing Issues Hepatitus Herpes High Blood Pressure HIV Infertility Metal Implants Keloids Kidney Disease Pacemaker Piercings PCOS TB Thyroid Disease Skin Tags Stroke Warts

Other: ______

Dermabrasion: yes / no **Last application:** MM / DD / YYYY

Are you pregnant: yes / no **Do you get your period:** yes / no **If yes, is it regular:** yes / no

Have you traveled outside of the country in the last 30 days: yes / no **Where:** ______

Have you had any major surgeries? yes / no **Specify:** ______

Are you preparring for sex reassignment surgery? yes / no **Planned Date of Surgery:** MM / DD / YYYY

Physician's Name: ______ **Phone:** ( )

Physician's Location: ______ **May we contact to discuss your treatment plan:** yes / no

Client Acknowledgement of Information

I understand health history information is important to my Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge, and I agree to update my health history assessment whenever there are changes. ______ Initials

I understand that a series of treatments is necessary to achieve permanent hair removal and my progress will be impacted by my personal hair growth rate, the science of electrology, and my individual physiological factors. ______ Initials

I have been advised of the post-treatment care, the healing process and the possible risks related to treatment. I agree to follow all aftercare instructions and to notify my Electrologist of any concerns or difficulty in healing. ______ Initials

I understand my electrologist has the right to refuse treatment if it is not beneficial to my health or skincare due to known or unknown health conditions I may have. ______ Initials

Client Name: ______ Signature: ______ Date: MM / DD / YYYY

If under 18, parent/guardian must sign.

Parent's Name: ______ Parent's Signature: ______ Date: MM / DD / YYYY

THANK YOU FOR YOUR BUSINESS