## Client Health History: Laser/ Light Energy Health History Intake

Name:		Date of Birth:			
Address:	City:	State	:	_Zip:	
Home/Cell Phone:	Work:				
Email:	Preferre	ed Contact: Cell	_ Work _	Email	
Emergency contact name:		Phone			
Relationship to you:					
<b>SKIN TYPE:</b> Review the skin types by your skin. This information will be use your treatment(s):	<u> </u>				
☐ I. Very fair skin; blonde or red hair	r; light-colored eyes; freckles cor	mmon			
☐ II. Fair skinned; light hair, light eye	es :				
☐ III. Very common skin type; fair; e	ye and hair color vary				
☐ IV. Mediterranean Caucasian sking	; medium to heavy pigmentation				
☐ V. Mideastern skin; rarely sun sen	nsitive				
☐ VI. Black skin; rarely sun sensitive	)				
Are you of Asian heritage (Class V) are	nd/or have a history of keloid sca	arring? □ Yes □	No		
Please list the products you use re	eqularly:	-			
Facial Cleanser					
Toner					
Scrubs					
Retinol	Glycolic Ac				
Enzymes	Peptides o				
Cosmetic History					
How would you describe your skin? I	Normal Combination Oily_	Dry			
When were you last exposed to the s	sun (including tanning beds)?				
Do you use sunless tanning products	s? Yes No If yes, whe	n was it last applie	ed?		
Do you have hyperpigmentation (dark	kening of the skin) or hypopigme	entation (lightening	of the ski	n) or marks	
after physical trauma? Yes No	_ If yes, please describe				
Have you had laser treatments in the	past? Yes No What boo	dy area was treate	d?		



## Client Health History: Laser/ Light Energy Health History Intake continued

Have you used Ad	ccutane in the past year'	? Yes No		
Are you using any	topical creams, lotions,	or oral antibiotics for a	cne, cancer, antiaging or h	nyperpigmentation?
Please List:				
Have you ever had	d any of the following inj	ectables or implants?		
Botox	Radiesse	Perlane	Collagen	Dysport
Juvederm	Restylane	Silicone	Sculptra	
Other:				
If yes, when?	What body	area(s)?		
	other cosmetic surgerie		_ No If yes, when?	
	ny of the following hair re VaxingTweezing			
Do you have mole Have you ever had		ea to be treated? Yes_ st or any other time fron		
Epilepsy Autoimmune	diseaseHerpes Sir	isHormone imbalamplexDiabetes	ncePregnancy and/o	
Have you consum	or raised scars from cuned drugs or alcohol in thone any recent surgery?	ne last 24 hours? Yes_		
Please list all vitan	nins and supplements in	cluding herbal remedies	s you take regularly	
Please list all curre	ent medications includin	g aspirin, ibuprofen, blo	od thinners, etc. you take	regularly
Is there anything e	else you would like us to	know?		

## Client Health History: Laser/ Light Energy Health History Intake continued

A current medical history is essential to execute appropriate treatment procedures.	
Client Name (Printed)	
Client Name (Signature)	_ Date:
Esthetician/Technician:	_ Date:

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.