CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we ask that you complete the following questionnaire. All information is strictly confidential.

CLIENT INFORMATION

Name: ____Date:____________________
Date of Birth:___/____/_______ Age:_____ Occupation: _________________________________
Address____
City/State_________________ Zip________________ Home Phone (______)_______-______________
Cell Phone (______)_______-___________ Email____________________________________
Emergency Contact Name & Phone____
How were you referred to Tahitian Pearl____
What would you like to achieve from your treatment today?_____________________________

MEDICAL HISTORY

Are you currently under the care of a physician/dermatologist? ❏ Yes ❏ No
If yes, what for:____

Do you have a history of erythema abigne? (A persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation) ❏ Yes ❏ No

Do you have any metal implants or artificial joints or a pacemaker? ❏ Yes ❏ No
If yes, explain:____

Have you ever had allergic reaction to any of the following:

❏ Latex ❏ Aspirin ❏ Lidocaine ❏ Hydrocortisone ❏ Hydroquinone ❏ Lavender ❏ Pumpkin
If so, please describe your reaction:____

Please list any other allergic or sensitive's you've experienced, including food:

List any surgeries you have had and how long ago:____________________________________

Do you smoke or drink alcoholic beverages? ❏ Yes ❏ No, If yes, how often?__________________

Do you form thick or raised scars from cuts or burns? ❏ Yes ❏ No, Explain__________________

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)
❏ Rash ❏ Irritation ❏ Peeling ❏ Sun Sensitivity ❏ Breakout

Which of the following best describes your skin type? (Please circle one type number)

I Creamy complexion	Always burns easily, never tans
II Light Complexion	Always burns, tans slightly
III Light/Matte Complexion	Burns moderately, tans gradually
IV Matte Complexion	Seldom burns, always tans well
V Brown Complexion	Rarely burns, deep tan
VI Dark Brown Complexion	Rarely burns, deeply pigmented

MEDICATIONS

List any oral medications you are presently taking: (please include what they are treating & how frequently they are taken)

____

____

What topical medications or retinoid creams are you currently using?

____

Do you have or have you ever had any of the following medical conditions?
(Please check all that apply)

❏ Cancer (Type) ________ ❏ Diabetes ❏ High Blood Pressure ❏ Herpes

❏ Frequent Cold Sores ❏ HIV/AIDS ❏ Keloid Scarring ❏ Skin Disease/Skin Lesions

❏ Syphilis ❏ Seizure Disorder ❏ Hepatitis (Type) ____ ❏ Hormone Imbalance

❏ Arthritis ❏ Blood Clotting Abnormalities ❏ Thyroid Imbalance/Disorder

❏ Implantable Defilbrillators ❏ Pacemaker ❏ Vitiligo ❏ Emotional/Psychiatric

❏ Auto Immune Disease ❏ Gonorrhea ❏ Chlamydia ❏ Any Active Infection

❏ Connective Tissue Disorder ❏ Renal (Kidney) Failure ❏ Lung Disease or Tuberculosis

❏ Heart Issues: ____________________ ❏ CHF (Congestive Heart Failure)

If you checked any of the above boxes, how long ago were you diagnosed? ____________

Do you have any other health problems or medial conditions? Please list: ____________

____

PERSONAL HISTORY

What is your ethnic background? ____
*Knowledge of ethnic background is necessary to properly determine safe treatment services and settings.

Have you ever used Accutane? ❑ Yes ❑ No
If yes, when did you last use it? ____

Have you ever had a chemical peel, laser or energy based treatment? ❑ Yes ❑ No
Explain:____How long ago:_______________________

Besides shaving, have you used any of the following hair removal methods in the past six weeks?

❑ Waxing ❑ Electrolysis ❑ Tweezing ❑ Depilatories

Have you had any recent tanning or sun exposure, or used any self-tanning lotions or treatments that change the color of your skin? ❑ Yes ❑ No

Do you have hyper-pigmentation (darkening of skin) or hypo-pigmentation (lightening of skin), raised scars, or marks after physical trauma? ❑ Yes ❑ No If yes, explain:__________________
____

Do you have piercings, tattoos or permanent make-up? ❑ Yes ❑ No If yes,
where:____

Have you had Dermal fillers or Botox injections? ❑ Yes ❑ No If yes, how long ago and
where?____

Do you wear contacts? ❑ Yes ❑ No

Do you develop cold sores/fever blisters? ❑ Yes ❑ No If yes, last breakout?_________________

Do you use Retin-A, Renova, Adapalene Hydroxl Acid or Retinol/Vitamin A derivative products?
❑ Yes ❑ No, if yes, when?____

For our female clients ONLY:

Are you pregnant or trying to become pregnant? ❑ Yes ❑ No

Are you lactating? ❑ Yes ❑ No

Any menopause problems? ❑ Yes ❑ No,
Specify:____

For our Male clients ONLY:

What is your current shaving system? ❑ Wet Shaving ❑ Electric

Do you experience irritation from shaving? ❑ Yes ❑ No

Do you get ingrown hairs? ❑ Yes ❑ No

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

____

____

____

____

Future Appointments/Contact:

May we call you at your home, work or cell phone number to confirm future appointments? ❏ Yes ❏ No

May we contact you via mail/email about future promotions and news? ❏ Yes ❏ No

May we use your before, during, and after photos on our social media? ❏ Yes ❏ No

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Name: (Please Print) ____

Client Signature: ____Date: ____/____/_________

Technician Signature: ____Date: ____/____/_________