REJUVENATION *medical Spa*

# MEDICAL HISTORY

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

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

Do you regularly use tanning salons or sun bathe? _____ How often? _____

Are you currently under the care of a dermatologist? Yes No

If yes, for what. _____

Are you currently under the care of a physician (besides dermatologist)? Yes No

If yes, for what: _____ _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

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

Cancer Diabetes High blood pressure Herpes Arthritis
Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions
Seizure disorder Hepatitis Hormone imbalance Thyroid imbalance
Blood clotting abnormalities Any active infection

Do you have any other health problems or medical conditions? Please list: _____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced)

Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents
Others: _____

**MEDICATIONS:**

What oral medications are you presently taking? Birth control pills Hormones Others (Please list):_____

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

What topical medications or creams are you currently using? Retin-A® Others (Please list). _____

What herbal supplements do you use regularly? _____

**HISTORY:**

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Threading Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

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

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: _____

**FEMALE CLIENTS ONLY:**

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

*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 technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.*

Signature _____ Date: _____