Spa and Esthetics Clinic
Health History

Prior to receiving treatment, we require an accurate health history to assist us in treating you safely. If your health status changes in the future please inform the treatment provider.

Last Name: _____ First Name: _____

Address: _____, _____, _____
(Street Name/#) (City) (Postal Code)

Date of Birth: M_____D_____Y_____ Gender (please circle): Female Male Other

Cell Phone #:_____ Work Phone #:_____ Home Phone #: _____

Email: _____ May we email you information: Yes _____ No _____

How did you hear about us? _____

What do you hope to accomplish during your treatment? _____
How do you rate your overall health? _____
Do you have a family physician or nurse practitioner? Yes _____ No _____
If yes Name: _____ Address: _____
Phone: _____ Frequency of Visits: _____
Have you had surgery in the past 12 months? Yes _____ No_____

Have you had any of these health conditions in the past or present?
(Please check all that apply and provide additional information in the space provided)

- ❑ HIV
- ❑ Hepatitis
- ❑ Cancer
- ❑ Diabetes
- ❑ TB
- ❑ Heart Condition
- ❑ Chronic Congestive Heart Failure
- ❑ Thyroid
- ❑ Heart Disease
- ❑ Pace Maker of Similar Device
- ❑ Hypersensitivity
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Herpes
- ❑ Infectious Disease
- ❑ Epilepsy
- ❑ Anxiety/Mental Health Issue
- ❑ Warts
- ❑ Arthritis
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Chronic Cough
- ❑ Phlebitis/Varicose Veins
- ❑ Hysterectomy
- ❑ Eczema
- ❑ Psoriasis
- ❑ Skin Conditions
- ❑ Fungus
- ❑ Corns
- ❑ Ingrown Toenails
- ❑ Other

Over ⇨

Additional comments &/or concerns: _____
_____
_____
_____

Please list all medications you are currently taking and the condition it treats: _____
_____
_____
Please list all allergies: _____
Have you ever had an allergic reaction to a product applied to your skin? Yes _____ No _____
If yes, which products or ingredients? _____
Describe your skin and your present skin care regime? _____
_____
What skin care product line are you currently using?
_____ Do you like it? Yes _____ No_____
Do you have a specific skin condition do you wish to correct? _____
Do you tan in a tanning bed? Yes _____ No _____
Do you use tobacco products? Yes _____ No _____
If Yes, what products and how frequently? _____
Do you use Accutane, Retinol, Tretinoin or Prescription Vitamin A on your skin? Yes _____ No_____
Please list sensitivities: _____
Are you currently under the care of a dermatologist? Yes _____ No_____
Do you have any internal pins, wires, artificial joints or metal implants? Yes _____ No _____
If so, where are they located? _____
Are you on any type of hormone therapy? Yes _____ No_____
Do you wear contact lenses? Yes _____ No_____

Women only: Are you pregnant or trying to become pregnant? Yes _____ No_____
If yes to being pregnant, when is your due date? _____

I certify that the information above is true and correct. I understand that it is my responsibility to inform the Esthetic Student and Staff of my current medical or health concerns, which are essential for proper treatment. My signature below constitutes my consent to treatment. I hereby give my consent and authorization voluntarily and release this establishment and its agents of any claims that I have or may have in the future connection with the treatment.

Client Name: _____ Signature: _____
(PRINT)

Student Name: _____ Date: _____
(PRINT)

Admin Use only: Medical History Updates

Date (DD/MM/YY)	Changes or No Significant Findings (NSF)	Student	Staff