CLIENT INFORMATION & MEDICAL HISTORY

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

PERSONAL HISTORY:

Client Name ____ Today's Date______________

Date of Birth_______________ Age_____________ Occupation____

Home Address ____City ______________State ______ Zip Code_________
May we add your address to our internal mailing list?_____Yes _______No

Contact number: ____________________________ Type: *(circle)* Home Work Cell *(carrier)* __________________
May we leave a voicemail at this number to confirm appointments?_____Yes _______No

E-mail Address: ____
We notify our customers about treatment specials and discounts on products by email.
(We do not disclose this information to anyone.)

Emergency Contact Name and Phone: ____

How were you referred to us? ____
If *referred by a friend, please let us know, as we offer discounts for referrals!*

Do you regularly sun bathe or use tanning salons? _________________ How Often? _____________________________

MEDICAL HISTORY:

Are you currently under the care of a physician? ❒ Yes ❒ No

If yes, for what: ____

____

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

❒ Cancer ❒ Diabetes ❒ High Blood Pressure ❒ Frequent Cold Sores/Fever Blisters ❒ Arthritis

❒ HIV/AIDS or exposure to person with known HIV ❒ Keloid Scarring ❒ Skin Disease/Skin Lesions

Disorders ❒ Hepatitis or known exposure to Hepatitis A, B or C

❒ Hormone Imbalance ❒ Thyroid Imbalance ❒Blood Clotting Abnormalities ❒ Any Active Infection

❒ Neuromuscular Disorders ❒ Emphysema ❒ Ulcers ❒ Lupus or Autoimmune Disorder ❒ Heart Disease

Do you have any other health problems or medical conditions not listed above?

Please list: ____

ALLERGIES

Have you ever had an allergic reaction? *(List any and all that you have had and describe the reaction you experienced)*

❒ Food ❒ Animal Protein ❒ Aspirin ❒ Lidocaine ❒ Hydrocortisone ❒ Glycerin ❒ Gluteraldahyde

❒ Gram Positive Bacteria ❒Sodium Carboxymethylcellulose ❒ Hydroquinone or Skin Bleaching Agents

❒ Latex or Rubber

Please list any addition allergies:____

MEDICATIONS

What prescription medications are you presently taking? ❒ Birth Control Pills ❒ Hormones ❒ Others

It is required that you list any others:____

What antibiotics do you use to treat infections? ____

Do you take any medication for heart conditions? _____No ________Yes ______________________________________

Are you on any mood altering or anti-depression medications? _____No ______Yes ______________________________

What topical medication or creams are you currently using? ❒ Retin A ❒ Others (Please list):

____

Are you currently taking any blood thinners? (Aspirin, NSAIDs, Coumadin, Vitamin E, Fish Oil) ______ No ______Yes

____

Do you regularly take any herbal supplements? (Ginkgo Biloba, St. Johns Wort etc.) _______No ______Yes

____

Are you currently taking any immunosuppressive drug or steroids? _________No ________Yes

____

Have you been taking Accutane within the last 6 months? _________ No _________ Yes

Do You Smoke? ________No ________Yes, if Yes how many packs____________ How many years____________

Have you ever had?

_____Microdermabrasion
_____Chemical peel
_____Collagen replacement therapy
_____Facial resurfacing
_____Facial surgery

Hormones (*females only*):

_____Regular periods
_____Take birth control or estrogen
_____Going through menopause
_____During pregnancy, did you ever get hyper pigmentation or masking?

How do you tan?

_____Burn
_____Usually burn
_____Burn then tan
_____Usually tan
_____Always tan

Pigmentation

_____Even
_____Uneven
_____Birthmark
_____Pregnancy mask

Vascularity:

Broken capillaries on:

_____Nose
_____Cheeks
_____Chin
_____Forehead
_____Entire Face

Acne:

Do you have a history of:

_____Pimples
_____Whiteheads
_____Blackheads
_____Enlarged pores
_____Flakiness
_____Acne Scars

What do you want to improve about your skin?

_____Fine lines
_____Frown lines
_____Acne Scars
_____Marionette lines
_____Color irregularities
_____Cellulite
_____Sun Damage
_____Large pores
_____Worry lines
_____Crow's feet
_____Deep smile lines
_____Facial scars
_____Stretch Marks
_____Overall skin tone

Your Skin is:

_____ Oily
_____ Dry
_____ T-zone/combination
_____Resilient
_____Sensitive
_____Not sure

What home skin-care products care are you now using?____

For our female clients:

Are you pregnant or trying to become pregnant? ❒ Yes ❒ No Are you breastfeeding? ❒ Yes ❒ No
Are you using contraception? ❒ Yes ❒ No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional 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: ________________________________ Client Name:________________________________

DOB:________________________________ Date: ________________________________

Thank you for visiting with us. We look forward to making you look and feel your best! ~The Staff at PURE

FOLLOW UP VISITS TO PURE

I have reviewed this medical history and verify that there have not been any changes since the original signature date. All changes have been noted with my initials and date.

Date	Signature
Date	Signature
Date	Signature
Date	Signature