

# Beutilash & more!

## Confidential Client Health History Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Your Health

1. Have you been under the care of a physician, dermatologist or other medical professional within the past year?  No  Yes, explain: \_\_\_\_\_
2. Any recent surgery, including plastic surgery?  No  Yes, explain: \_\_\_\_\_
3. Any skin cancer?  No  Yes, explain: \_\_\_\_\_
4. Have you had any piercings, tattoos, or permanent cosmetics?  No  Yes, If yes, where on your person? \_\_\_\_\_
5. Have you ever had a body spa treatment before?  No  Yes, when: \_\_\_\_\_
6. 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)

Cancer

Hormone imbalance

Systemic disease

High blood pressure

Spinal injury

Thyroid condition

Hysterectomy

Diabetes

Heart problems

Varicose veins

Arthritis

Asthma

Eczema

Epilepsy

Headaches (chronic)

Hepatitis

Herpes

Frequent cold sores

Immune disorders

HIV/AIDS

Lupus

Metal bone pins or plates

Phlebitis, blood clots, poor circulation

Blood clotting abnormalities

Psychological treatment

Skin disease/skin lesions

Insomnia

Keloid scarring

Seizure disorder

Any active infection

Fever blisters

7. Has your physician discussed concerns about raising your body temperature?  No  Yes, explain:

\_\_\_\_\_

8. Do you smoke?  No  Yes, how much: \_\_\_\_\_

9. Do you follow a restricted diet?  No  Yes, specify: \_\_\_\_\_

10. Do you follow a regular exercise program?  No  Yes, explain: \_\_\_\_\_

11. What is your stress level? High  Medium  Low

12. List any medications you take regularly: \_\_\_\_\_

13. List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly: \_\_\_\_\_

14. Do you use Retin-A, Renova, Adapalene Hydroxyl3) Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products?  No  Yes, describe: \_\_\_\_\_

15. Have you used any of the products in question #14) In the last 3 months?  No  Yes

16. Have you used an acne medication?  No  Yes when? \_\_\_\_\_  
Which Drug? \_\_\_\_\_

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

Describe \_\_\_\_\_

18. Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?  No  Yes Describe \_\_\_\_\_

19. List your daily consumption of: Water \_\_\_\_\_ Caffeine \_\_\_\_\_ Alcohol \_\_\_\_\_

20. Do you experience any problems sleeping?  No  Yes

21. How many hours do you typically sleep each night? \_\_\_\_\_

22. Do you wear contact lenses?  No  Yes

23. Have you been exposed to the sun or used a tanning bed in the last 48 hours?  No  Yes

24. How frequently are you exposed to the sun or use a tanning bed?

\_\_\_ Infrequently \_\_\_ Frequently \_\_\_ Regularly

25. Do you have any metal implants or wear a pacemaker?  No  Yes

26. Have you ever experienced claustrophobia?  No  Yes

27. Do you suffer from sinus problems?  No  Yes

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

29. Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)  Cosmetics  Medicine  Food  Animals  Sunscreens  Iodine  Pollen  
 AHA's  Fragrances  Shellfish  Latex  Drugs

Other: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**Female Clients Only:**

30. Are you taking oral contraceptives?  No  Yes

If yes, specify: \_\_\_\_\_

31. Any recent changes to or from your contraceptive treatment?  No  Yes

If so, what and when? \_\_\_\_\_

32. Are you pregnant or trying to become pregnant?  No  Yes

33. Are you lactating?  No  Yes

34. Any menopause problems?  No  Yes, specify: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

In consideration for receiving services at Beutilash & more! LLC, I hereby release, waive, discharge, and covenant not to sue Beutilash & more! LLC, its officers, agents, servants, and employees or other business entities owned, operated or controlled either in whole or in part by Beutilash & more! LLC from any and all liability, claims, demands, actions, and causes of action related to any loss, damage, or injury that may be sustained by me or property belonging to me, whether caused by negligence or otherwise, while participating in such activity or while on Beutilash & more! LLC premises. I am fully aware of the risks involved and hazards connected with spa and salon treatments, and I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, that may be sustained by me, or any loss or damage to property owned by me as a result of being engaged in such an activity, whether caused by the negligence or otherwise.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_