Medical History Form

Name: ____ Date:_________________________________
Last First

Address: ____ City: ________________________ST:______ Zip:__________

Email: ____ Phone: _________________________________

Emergency Contact Name and Phone ____
How did you hear about Skin Renew Day Spa? ____

Which of the following best describes your skin type?

Always burns, never tans (I) Always burns, sometimes tans (II) Sometimes burns, tans gradually (III)
Rarely burns, tans easily (IV) Skin darkens, never burns (V) Very dark skin (VI)

How old is your tattoo? ______________________Is it homemade or professional?________________________________

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No If yes, for what:________________________________
Are you currently under the care of a dermatologist? Yes No If yes, for what:______________________________
Have you ever had a reaction to a laser/heat treatment or radiation therapy? No / If yes, when:___________________
Do you have any of the following medical conditions? (Please check all that apply)

Cancer Diabetes Herpes Arthritis Frequent cold sores HIV/AIDS
Keloid scarring Skin disease/Skin lesions Seizure disorder Hepatitis
Blood clotting abnormalities Any active infection Migraine headaches Heart disease
Autoimmune disease Poor Circulation Skin cancer (location/type):________________________

Do you have any other health problems or medical conditions? Yes No
Please list: ____

MEDICATIONS

It is very important for you to list ALL medications you are taking. Certain medications, such as light-sensitive medications, can have serious interactions with the laser.

What oral or topical medications are you presently using?
Please list: ____
____
____
____
____
____

Have you ever used Accutane or Retin-A©? Yes No
If yes, when did you last use it? ____

Have you ever had an allergic reaction to any medications? Yes No
If yes, please list____

Have you recently taken antibiotics? Yes No
If yes, please list antibiotic and reason for use____

HISTORY

Do you currently have a sunburn? Yes No
Do you currently have a tan? Yes No
Do you form thick or raised scars from cuts or burns?____

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____

Have you had any previous laser or IPL treatments of any kind? Yes No
If yes, did you have any problems (pigmentation issues, blisters, burns) Yes No
If yes, please describe____

FOR FEMALE CLIENTS ONLY
Are you pregnant or trying to become pregnant? 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, doctor or nurse of my current medical or health conditions and to update this history at each visit. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature____ Date __________________