ELECTROLOGY
CLIENT INFORMATION

In order to provide you with the most appropriate treatment, please complete the following questionnaire.

Please do not leave any areas blank

PERSONAL INFORMATION:

Client Name:____Today's Date__________

Date of Birth_________________Age__________Occupation____

Home Address____ City_________________________

State_____Zip Code__________Email Address____

Mobile/Text Phone ( )______________Home Phone ( )_____________Work/Other Phone ( )______________

2 forms of communication are required.

Emergency Contact Name and Phone____

What areas are you mainly interested in for Electrolysis? Now or in the future. (Please circle all that apply)

Abdomen, Areola/Breast, Back, Beard, Bikini, Chest, Chin, Face, Glabella, Hands, Inner thighs, Upper Lip, Neck, Face, Shoulders, Partial Arms Under-Arms, Hands/Fingers, Feet/ Toes
Other: ____

Have you ever had laser hair removal or electrolysis? ❑**Yes** ❑**No**

What body areas?______________ For how long?_________ When was your last treatment?______

What was your experience and detailed skin reaction? ____

____

Please check all hair removal methods you've used in the past six weeks.

❑ Shaving ❑ Waxing ❑ Electrolysis ❑ Laser ❑ Tweezing ❑ Stringing ❑ Bleaching ❑ Depilatories ❑ None

Do you have PCOS, Hirsutism, HS (Hidradenitis suppurativa) ❑ **Yes** ❑ **No**

Are you on HRT (Hormone Replacement Therapy) ❑ **Yes** ❑ **No**

If yes, please explain:____

Do you have other hormone considerations? ❑ **Yes** ❑ **No**

If yes, please explain:____

Do you form keloids/thick or raised scars from cuts or burns? ❑ **Yes** ❑ **No**

Do you experience pigmentation changes following physical trauma? ❑ **Yes** ❑ **No**

Have you had a recent chemical peel, dermal planing, needling or microdermabrasion? ❑ **Yes** ❑ **No**

MEDICAL HISTORY

Are you currently under the care of a physician or dermatologist? ❑ **Yes** ❑ **No**

If yes, please explain:____

Do you have a history of erythema ab igne, ❑ **Yes** ❑ **No**

Do you have any of the following medical conditions? ❑ **Yes** ❑ **No**

(Please check all that apply) ❑ Cancer ❑ Melanoma ❑ Diabetes ❑ High blood pressure ❑ Herpes ❑ Frequent cold sores ❑ HIV/AIDS ❑ Keloid scarring ❑ Skin disease/Skin lesions ❑ Vitiligo ❑ Hepatitis ❑ Hormone imbalance ❑ Thyroid imbalance ❑ Eczema/Psoriasis ❑ Blood clotting abnormalities ❑ Photosensitivity ❑ Any active infection ❑ Pacemaker/Defibrillator **❑ Metal Impants of any kind? ❑ Other

Please explain____

Do you have any other health problems or medical conditions? ❑ **Yes** ❑ **No**

Please explain____

Have you ever had an allergic reaction to any of the following? ❑ Latex ❑ Lidocaine ❑ Hydrocortisone ❑ Aloe ❑ Other Allergies:_________________________________

For our Female Clients: Are you pregnant or are you trying to become pregnant? ❑ **Yes** ❑ **No**

MEDICATIONS

What prescription and/or OTC (over the counter) oral medications are you presently taking?

❑ Birth control pills ❑ Hormones ❑ Others ❑ **None**

List all____

Have you ever used Accutane? ❑ Yes ❑ No If yes, when ____________

What topical medications or creams are you currently using? ❑ RetinA ❑ Clindamycin ❑Others ❑None
List ____

* 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 of my current medical or health conditions and to update this history prior to each treatment.

*Signature (Guardian Signature if under 18 yrs)___________________________Date__________