Client Health History: Radio Frequency/High Frequency Treatment of Skin Irregularities Health History Intake

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work: _____

Email: _____ Preferred Contact: Cell____ Work ____ Email _____

Emergency contact name: _____ Phone: _____

Relationship to you: _____

Are you over the age of 18 years? Yes☐ No☐

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

- ☐ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
- ☐ II. Fair skinned; light hair, light eyes
- ☐ III. Very common skin type; fair; eye and hair color vary
- ☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation
- ☐ V. Mideastern skin; rarely sun sensitive
- ☐ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ☐ Yes ☐ No

Cosmetic History

How would you describe your skin? Normal☐ Combination☐ Oily☐ Dry☐

When were you last exposed to the sun (including tanning beds)? _____

Have you ever had treatments for vascular veins, pigmented lesions, or other unwanted lesions? Yes ☐ No☐

If yes, when? _____ What body area(s) were treated? _____

Describe your experience _____

Have you used Accutane in the past year? Yes☐ No☐

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation?

Please List: _____

Have you ever had any of the following injectables or implants?

Botox ☐	Radiesse ☐	Perlane ☐	Collagen ☐	Dysport ☐
Juvederm ☐	Restylane ☐	Silicone ☐	Sculptra ☐	

Other: _____

If yes, when? _____ What body area(s)? _____

Continued ⇨

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Health History

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 _____

_____

Do you form thick or raised scars from cuts or burns? Yes ☐ No ☐

Have you had chemotherapy in the past 6 months? Yes ☐ No ☐

Do you have any allergies to medications, food, latex, topical products, and/or other substances? _____

_____

Do you have any of the following conditions?

☐ Epilepsy ☐ Pregnancy and/or breastfeeding ☐ Autoimmune disease ☐ Herpes Simplex ☐ Diabetes

☐ Dental implants, crowns, metal fillings ☐ Pacemaker or internal defibrillator

☐ Implanted neuro stimulators or other internal electric device

☐ Metal implants or other implants in the treatment area, i.e. IUD, screws, plates ☐ Varicose veins

☐ History of skin disorders

Do you have a history of Erythema Ab Igne (EAI), a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? Yes ☐ No ☐

Do you have any other health condition not mentioned here? Yes ☐ No ☐

If yes, please list _____

Have you consumed drugs or alcohol in the last 24 hours? Yes ☐ No ☐

Have you undergone any recent surgery? Yes ☐ No ☐ I

f yes, please explain _____

Please list all vitamins and supplements including herbal remedies you take regularly _____

_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____

_____

Is there anything else you would like us to know? _____

_____

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 esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) _____

Client Name (Signature) _____ Date: _____

Esthetician/Technician: _____ Date: _____