Star Girl Aesthetics PLLC

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_____

Home Phone_____ Work Phone_____ Email_____

Emergency Contact Name and Phone_____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons?_____How often?_____

MEDICAL HISTORY

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

□Cancer □Diabetes □High blood pressure □Herpes □Arthritis □Frequent cold sores □HIV/AIDS □Keloid scarring □Skin disease/Skin lesions □Seizure disorder □Hepatitis □Hormone imbalance □Thyroid imbalance □Blood clotting abnormalities □Any active infection

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

If yes, for what:_____

Do you have any other health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List any and all reactions you experienced) □None □Food □Animal Protein □Aspirin □Lidocaine □Hydrocortisone □Hydroquinone or skin bleaching agents □Others**:**_____

MEDICATIONS

What prescription medications or herbal supplements are you presently taking?

□ Birth control pills □ Hormones □ RetinA □ Others (It is required that you list all of them):

_____

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? □Yes □No Are you breastfeeding? □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_____ Date:_____