CLIENT INFORMATION AND MEDICAL HISTORY

All information is strictly confidential

PERSONAL HISTORY:

Client Name _____ Today's Date _____

Address:_____Apt#_____

City:_____ State:_____ Zip Code:_____

Cell Phone:_(____)_____Carrier (ie Verizon, AT&T, Sprint, Tmobile, etc for text reminders of appointments):_____

Email (will not be shared, used for appt. confirmation, **please write legibly**):_____

Birth Date:_____ Age:_____ Gender: M F Occupation:_____

Emergency Contact Name and Phone: _____

How did you hear about us? _____Any Other?_____

What is your ethnicity? (ie German, Italian, Irish Etc. This information needed only to determine your skin type)_____

Which of the following best describes your skin type? (Please circle one)

I - Always burns, never tans
II - Always burns, sometimes tans
III - Sometimes burns, always tans
IV - Rarely burns, always tans
V - Brown, moderately pigmented skin
VI - Black skin

MEDICAL HISTORY:

Do you have any chronic medical conditions which we should know about? Yes No
If so, please list:_____
Are you currently under the care of a physician or dermatologist? Yes No
If yes, for what: _____
Have you ever had an allergic reaction or allergies to any of the following? (Please circle all that apply)
Latex Red Dye Lidocaine Tetracaine Benzocaine Medications
Explain reaction: _____
Do you smoke: yes _____ no_____ **Please understand studies show that people who smoke are 70% slower at losing their tattoo**
Have you taken any anticoagulants in the past 6 months? Yes No
Do you have a history of cold sores, fever blisters, herpes 1 or 2? *the use of lasers can trigger an outbreak Yes No
Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No
Have you ever had gold therapy or taken gold salts? (for arthritis) Yes No

(continued on next page)

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

Cancer Diabetes High blood pressure Arthritis HIV/AIDS Hepatitis

Skin disease/Skin lesions Seizure disorder Thyroid imbalance Blood clotting abnormalities

Any active infection ?

Please explain:_____ (Continue on back side if needed)

Have you had any previous laser treatments? _____If yes, what type(s)?_____

MEDICATIONS:

Are you currently taking any Oral Medications? _____
Accutane? _____ , Retin-A?_____, Topical Creams?_____
Any other medications known to increase sensitivity to sunlight?_____

SKIN HISTORY:

Have you had any recent tanning or sun exposure, tanning bed? Yes No (Just in the area to be treated)
Have you recently used any self-tanning lotions or spray tan? Yes No (**Must wait two weeks before treatment**)
Do you form thick or raised scars from cuts or burns (Keloid scarring)? Yes No
Do you get hyper-pigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin) or marks after physical trauma? Yes No
Please describe: _____

For our female clients:

Are you pregnant or trying to become pregnant? Yes No
Are you breast feeding? Yes No

FOR TATTOO CUSTOMERS: (Tattoos to be treated only)

Location/Size:_____Tat Age:_____ Treated before? _____ # times_____ Colors_____

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Location/Size:_____ Tat Age:_____ Treated before? _____ # times_____ Colors_____

PLEASE BE AWARE:

We need to be able to contact you! Please make sure you give us a cell phone number. Please cancel any appointments 24 hours in advance. No Shows will be charged a $25 fee. Photos of your tattoo or treatment area may be put on social media page unless you indicate you are opposed to having yours submitted. Your face will never appear. ***WE HAVE NO WAY OF KNOWING HOW MANY SESSIONS IT WILL TAKE TO REMOVE YOUR TATTOO.**

ACKNOWLEDGEMENT:

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, esthetician, therapist, doctor or nurse 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.

Client Signature _____Print Name_____Date:_____

Provider Signature _____Print Name_____Date:_____