PLACE TO BE YOU

Client Medical History Form

Date ____________________
Name ______________________________________ Birthday ____________________
Address ____
Phone ___________________________ Email __________________________________
Emergency Contact Person ______________________ Email ______________________

Name(s) of Physician(s):____
Are you currently taking any medication? Yes___ No___
If so, please list all medication you are currently taking or have taken in the last 48 hours:____
Are you allergic to any medications? Yes___ No___
If so, please explain and list medical allergies:___________________________________
Do you have any food allergies/sensitivities? Yes___ No___
If so, please explain and list:____

Please list any previous surgeries
____

Female Client Information
Are you currently in Menopause? Yes___ No___
Post Menopause? Yes___ No___

Do you have or previously had any of the following: (circle YES or NO)
Yes No Hormonal Imbalances
Yes No Pregnant, If so, how many weeks?
Yes No Birth Control, if so, please list _________________________________
Yes No Hormones, if so, please list ____________________________________
Yes No Have you ever had treatment for hair removal,
if so, please list the areas ____
Yes No Acne
Yes No Hearing Aid
Yes No Cancer
Yes No Sores
Yes No Heart Condition
Yes No Cold Sores
Yes No Hemophilia
Yes No Contact Lenses
Yes No Hepatitis/Jaundice
Yes No Dermatitis/Eczema
Yes No HIV
Yes No Diabetes
Yes No Keloid Scars
Yes No Genital Herpes

Yes No Metal in Body
Yes No Latex Allergy
Yes No Moles
Yes No Shingles
Yes No Pacemaker
Yes No Tattoo
Yes No Bleeding Disorder
Yes No Tuberculosis
Yes No Problems w/ Healing
Yes No Targeted Area of Treatment
Yes No Accutane
Yes No Retin-A Burns
Yes No Chemical Peel
Yes No Glycolic Acid
Yes No Laser Resurfacing
Yes No Liposuction
Yes No Photo-derm
Yes No Intense Light
Yes No Sunburn
Yes No Pulsed Dye Laser
Yes No Skin Grafts

I acknowledge that the above information is true and accurate to the best of my knowledge.

Signature________________________________ Date:__________________

Print name ______________________________