Symmetry MedSpa and Laser Center

334-558-0262

www.symmetrymedspa.com

·Hair Removal· Vein Removal· Sunspot Removal· Acne Scar Treatment· Skin Resurfacing· Fillers·
·Botox ·Skin Tightening· Tattoo Removal· Skin Care Products· Nail Fungus·

Health History

Date: ____________________

Name: ____________________________________ Date of Birth: _____________ SSN:___________

Address: ____

City/State:____Zip:__________________________

Home Phone: __________________Work Phone: _________________Mobile: __________________

Email: ____

Emergency Contact: ______________________________ Phone: _____________________________

Physician: _______________________________________ Phone: _____________________________

Have you been under the care of a physician, dermatologist or other medical professional within the past year? __ No __ Yes Explain:

____

Any recent surgery, including plastic surgery? __No __ Yes Explain:

____

Any skin cancer? __No __Yes Explain:

____

Have you had any piercings, tattoos, or permanent cosmetics? __No __Yes, If yes, where on your person?

____

____

Have you ever had a body spa treatment before? __No __Yes, when:

____

____

Confidential Client Health History Form—continued

Have you had any of these health conditions in the past or present? Check all that apply and use the space on the next page to provide additional information.

Cancer	☐	Headaches (chronic)	☐
Hormone imbalance	☐	Hepatitis	☐
Systemic disease	☐	Herpes	☐
High blood pressure	☐	Frequent cold sores	☐
Spinal injury	☐	Immune disorders	☐
Thyroid condition	☐	HIV/AIDS	☐
Hysterectomy	☐	Lupus	☐
Diabetes	☐	Metal bone pins or plates	☐
Heart problem	☐	Phlebitis, blood clots, poor circulation	☐
Varicose veins	☐	Blood clotting abnormalities	☐
Arthritis	☐	Psychological treatment	☐
Asthma	☐	Insomnia	☐
Eczema	☐	Keloid scarring	☐
Epilepsy	☐	Skin disease/skin lesions	☐
Seizure disorder	☐	Any active infection	☐
Fever blisters	☐		

Please Explain:

____

____

____

____

Has your physician discussed concerns about raising your body temperature? __No __Yes
Explain:____

____

Do you smoke? __No __Yes

Do you follow a restricted diet? __No __Yes, Description: __________________________

____

Do you follow a regular exercise program? __No __Yes

What is your stress level? High__ Medium__ Low__

List any medications you take regularly: ____________________________________

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly: ____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? __No __Yes, describe: ________________________________

____

Have you used any of these products in the last 3 months? __No __Yes

Have you used an acne medication? __No __Yes, when? Which drug? ________________________

Do you form thick or raised scars from cuts or burns? __No __Yes

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? __No __Yes, describe: ____________________________________

____

List your daily consumption of: Water __________ Caffeine __________ Alcohol __________

Do you experience any problems sleeping? __No __Yes

How many hours do you typically sleep each night? _________

Do you wear contact lenses? __No __Yes

Have you been exposed to the sun or used a tanning bed in the last 48 hours? __No __Yes

How frequently are you exposed to the sun or use a tanning bed?

Infrequently Frequently Regularly

Do you have any metal implants or wear a pacemaker? __No __Yes

Have you ever experienced claustrophobia? __No __Yes

Do you suffer from sinus problems? __No __Yes

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs Fragrance Shellfish

Latex Drug Other: __________________

If yes, please describe allergy and reaction: ____

____

Female Clients Only:

Are you taking any birth control? __ No__ Yes, Explain: ____

Any recent changes to or from your contraceptive treatment? __ No __ Yes, If so, what and when?

____

____

Are you pregnant or trying to become pregnant? __No __Yes

Are you lactating? __ No __ Yes

Any menopause problems? __ No __ Yes Explain:

____

____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Printed Name: ____

Signature: ____ Date: ___________