Patient Skin Care Information Sheet

Name_____

What oral medications are you presently taking?
( ) ACCUTANE ( ) birth control pill ( )hormones
( ) other please list _____
_____

Have you ever used Acutane? ( )Yes ( ) No . If yes when did you last use it?_____

What topical medications or creams are you currently using? ( ) Retin A
( ) others (please list) _____

When exposed to the sun, WITHOUT PROTECTION for about one hour my skin… (Please circle)

Always burns, never tans
Always burns, sometimes tans
Sometimes burns, sometimes tans
Always tans

Have you had any recent tanning or sun exposure that changed the color of your skin?
( ) Yes ( ) No

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

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 _____
_____

For our Hair Removal clients: Have you ever had laser hair removal? ( ) Yes ( ) No

Have you used any of the following hair removal methods in the past six weeks? ( ) shaving
( ) waxing ( ) electrolysis ( ) plucking ( ) tweezing ( ) stringing ( ) depilatories

For our Female clients: Are you pregnant or trying to become pregnant? ( ) Yes ( ) No

Are you using contraception? ( ) Yes ( ) No

Are you breastfeeding ( ) Yes ( ) No

Allergies

Have you ever had an allergic reaction to any of the following? (please check all that apply and describe the reaction you experienced.) ( ) food ( ) latex ( ) cosmetics ( ) aspirin ( ) lidocaine ( ) hydrocortisone ( ) hydroquinone or skin bleaching agents ( ) others: _____
_____

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 as a current medical history is essential for the caregiver to execute treatment procedures.

Signature_____Date_____