Health History Questionnaire and Waiver

Please answer the following questions so that your Skincare Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skincare Specialist to accurately analyze and assess your skin care needs.

Name:		Date:	
Address:			
City:		State:	Zip:
Cell Phone:	Cell Carrier:	Home Phone:	
Business Phone:		Date of Birth:	
Email Address:			
How did you hear about us?			

Health History

What type of work do you do?

Are you presently under a Physician's care?	Yes □	No □

Medications you are currently taking:

Have you ever used Accutane?	Yes □	No □

If yes: When?

Please circle the following conditions you have now or in the past:

Pacemaker	Cold Sores	Cancer	Migraines
Stroke	Diabetes	Thyroid Disorder	Metal Implants in Body
Neuromuscular Disorder	Lupus	Varicose Veins	Contacts

Please list any other conditions not listed:

Do you have any Allergies to the following?

Prescription Drug Name of Drug:	Circle any below if you have allergy to any of the following:

Latex Lidocaine Hydroquinone or skin bleaching agents Hydrocortisone Epinephrine

Have you ever had Herpes Simplex or Cold Sores?	Yes □	No □

Female Clients:

Are you on hormone replacement therapy?	Yes □	No □
Are you currently taking birth control pills?	Yes □	No □
Are you pregnant or nursing?	Yes □	No □

Please list any other information that you feel is important for us to know:

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. Initial___________

I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s). . Initial___________

I understand that after I sign this waiver, I agree to inform the provider/staff with ANY changes pertaining to the above questionnaire prior to any future treatments. 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 now and in the future. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that payment is due at time of all services and products. **There are NO REFUNDS on any services.** This includes but is not limited to Botox, Xeomin, Radiesse, Juvederm, Belotero, Photofacials, Laser Hair removal, DermaPen, Facials, Microdermabrasion, Chemical peels, tinting or waxing. ***There will be a $50.00 charge for missed appointments not cancelled 24 hours prior to your appointment. If you arrive 15 minutes or later to your appointment, you will be rescheduled. .*** *Initial*___________

Client Signature:	Date: