ADVANCED
skin • care

Client Information and Medical History

Client Name_____ Today's Date_____

Date of Birth_____Age_____Occupation_____

_____

Address_____City_____State_____Zip_____

Mobile Number_____Home Number_____

_____

Emergency Contact Name and Phone_____

_____

How were you referred?_____

_____

Are you currently under the care of a physician? ___ Yes, __No If yes, for what?_____

_____

_____

Are you currently under the care of a Dermatologist?_____Yes,___No If yes, for what?_____

_____

_____

Do you have any of the following medical conditions? Please check all that apply

___Cancer ___High blood pressure ___Diabetes ___Arthritis

___Herpes ___Frequent cold sores ___Hepatis ___HIV/Aids

___Keloids ___Blood clotting disorder ___Thyroid imbalance ___Hormone imbalance

___Seizures ___Skin disease/lesions ___Any active infections ___Rosacea

___Stroke plugs ___ Allergy to metals ___ Tear duct ___MRSA/Staph

___Shingles ___Pregnant or Nursing ___Drug Allergies ___ Epilepsy/Seizures

___Tuberculosis ___Heart condition/Pacemaker ___Cataract or Eye Surgery ___ Ocular Herpes

___Alopecia ___Autoimmune Disorders ___Organ Transplant ___Vitiligo

___Kidney Disease ___Accutane Treatments ___Allergies to Makeup ___Eczema/Dermatitis

Please Explain:

_____
_____
_____
_____
_____

_____
_____

Do any of the following apply to you? Please check all that apply.

___Smoker ___Using lash growth serum (Latisse) ___Undergoing Chemo or Radiation

___Plastic Surgery ___Filler Injections ___Hypo or Hyper-pigmentation

___Lidocaine Allergy ___Wear Contacts ___Skincare Allergy

___Permanent Makeup ___Skin sensitivities ___Oily or Combination skin

___Tanning bed use ___ Dry or Dehydrated Skin ___Laser Treatments

Please Explain:

_____
_____
_____
_____

List all supplements and medications that you take regularly, including hormones, vitamins, etc.

_____
_____

_____
_____

List all topical prescription and skincare products you are using on your skin, including makeup.

_____
_____
_____
_____

Lists any allergies including nuts, seafood, coconut, aspirin, sulphur, lidocaine, hydrocortisone, hydroquinone

_____
_____

Consents:

I consent to facial treatments performed by Advanced Skin Care. Treatments may include facials, microderm facials, waxing and tinting. If other treatments are recommended that require more specialized applications or procedures, there will be a separate consent to be signed.

I consent to have photographs taken for purposes of identification, pre and post treatments, and education. Photographs that could identify me will only be used for charting.

I understand that there is a 24hour cancellation policy. A charge of $50 will be applied at your next appointment.

I certify that the preceding medical, personal and skincare history statements are true and correct. I am aware that it is my responsibility to inform Advanced Skin Care of my current health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature:_____
Date:_____

Practitioner Signature:_____
Date:_____