501 Gateway Drive ● Suite 104 ● Clayton, NC 27520
www.SpaNeoClayton.com 919-550-9355

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name: ____ Today's Date: _______________

Date of Birth: ____/____/____ Age: ______ Occupation: _____________________________________

Home Address: __________________ City: ________________ State: ______ Zip Code: _____________

Home Phone: (____) ____________ Work Phone: (____) _________ Cell Phone: (____) ____________

Email Address: ______________________Emergency Contact Name & Phone: ___________________________

MEDICAL HISTORY

Are you currently under the care of a physician or dermatologists? ☐ Yes ☐ No
If yes, for what? ____

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

☐Cancer	☐Stroke	☐Herpes	☐Headaches
☐Diabetes	☐HIV/AIDS	☐Frequent Cold Sores	☐Fibromyalgia
☐High Blood Pressure	☐Seizure disorder	☐Thyroid imbalance	☐Open Cuts/ Wounds
☐Heart Disease	☐Hepatitis	☐Skin disease/lesions	☐Varicose Veins
☐Arthritis	☐Hormone imbalance	☐Blood clots	☐Keloid Scarring
☐Dizziness/Passing out	☐Contagious Disease	☐Bruises/Bleeding	☐Rosacea
☐Lupus	☐Any active infection	☐Dermatitis	Other:

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 ☐Aspirin ☐Lidocaine ☐Hydroquinone or skin bleaching agents ☐ Fish
☐ Ingredient in skin care products ☐ Others: ____

MEDICATIONS

What oral medications are you presently taking? ☐Birth Control Pills ☐Hormones
☐Others (Please list) ____
____

Are you using any of these prescribed products?
☐Trentinoin (Retin-A, Micro®, Renova, Avita)
☐Adepalene (Differin)
☐Azelaic Acid (Azelex®, Finacea™)
☐Tazarotene (Tazorac®)
☐Isotretinoin (Accutane)
☐Triluma™
☐Metrogel
☐Any other antibiotics____

What herbal supplements do you use regularly? ____

HISTORY

Do you or have you had any of the following in the last 14 days?

☐ Facial Cosmetic Surgery ☐Botox injections ☐Fillers ☐Light Treatments ☐Laser Resurfacing
☐Microdermabrasion ☐Chemical Peels ☐Extractions ☐Permanent Cosmetics ☐ Waxing
☐Laser Hair Removal ☐Hair Treatments (color, perm, etc.) ☐Tanning/Sun bathing ☐Self-Tanning

Do you form thick or raised scars from cuts or burns? ☐*Yes* ☐*No*

Do you have Hyper pigmentation (darkening of the skin) or Hypo pigmentation (lightening of the skin) or marks after physical trauma? ☐Yes ☐No If yes, please describe: ______________________________

FEMALE CLIENTS ONLY

Are you currently having or due for your menstrual period? ☐Yes ☐No
Are you pregnant or trying to become pregnant? ☐Yes ☐No
Are you lactating? ☐Yes ☐No

SKIN

Which of the following best describes your skin type?

☐Always burns, never tans ☐ Always burns, sometimes tans ☐ Sometimes burns, always tans
☐ Rarely burns, always tans ☐ Brown, moderately pigmented skin ☐Black Skin

Please check if you are presently using any of the following?

☐Benzoyl Peroxide ☐ Glycolic Acid ☐ Lactic Acid ☐ Resorcinol ☐Salicylic Acid ☐ Sulfur
☐ Vitamin A ☐Vitamin C ☐Hydrocortisone ☐ Hydroquinone

What skin care products are you're currently using?

Face: ☐soap ☐cleanser ☐toner ☐moisturizer ☐masque ☐exfoliants ☐eye products
☐Other: ____

How would you describe your skin?

Please specify: ____

What skin conditions do you want to improve?

☐Acne/ or breakouts ☐ Facial Scarring ☐Hyperpigmentation (freckles, age spots) ☐Enlarged pores
☐Fine Lines/ Wrinkles ☐ Rosacea ☐ Uneven Tone ☐ Uneven Texture ☐ Dehydration ☐ Oily ☐Sun Damaged
☐Other ____

Is there any other necessary information you skin care specialists should know before beginning your treatment? If yes, explain____

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. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: ____ Date: ________________

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

☐Please check if permission is granted to use before and after pictures of the treatments.

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