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General Information

Name _____ Birthday _____
Address _____
City _____ State _____ Zip Code _____
Phone # _____ Email_____
Occupation_____
Emergency Contact Name _____ Phone # _____
Would you like to be added to our email list for specials and discounts? ☐ Yes ☐ No
How did you hear about us? _____

Medical History

Please check all that apply:

- ☐ Acne
- ☐ Depression
- ☐ Eczema
- ☐ Fever Blisters
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypo Pigmentation
- ☐ Low Blood Pressure
- ☐ Sinus Infection
- ☐ Pregnant
- ☐ Rashes
- ☐ Shingles
- ☐ Hyper/Hypo Thyroid
- ☐ Accutane
- ☐ Arthritis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Hyper Pigmentation
- ☐ Insomnia
- ☐ Lupus
- ☐ Surgery: _____
- ☐ Psoriasis
- ☐ Seborrhea
- ☐ Skin Cancer
- ☐ Warts

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please explain: _____

Have you had any facial or dermatology services in the past 30 days? ☐ Yes ☐ No
If yes, please explain: _____

Do you have any allergies? ☐ Yes ☐ No
If yes, please explain: _____

Skin Care History

Check the products that you currently use (please select all that apply):

☐ Body Lotion
☐ Body Scrub
☐ Day Cream
☐ Eye Cream
☐ Facial Soap
☐ Hand Cream
☐ Night Cream
☐ Other: _____

☐ Body Soap
☐ Cleansing Cream
☐ Eye Makeup Remover
☐ Exfoliants
☐ Facial Scrub
☐ Neck Cream
☐ Skin Toner/Astringent

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache
☐ Inflammation ☐ Insomnia ☐ Muscle Cramps ☐ Stress

Important Information

What concerns do you have regarding your skin? Please select all that apply:

☐ Acne/Breakouts
☐ Broken Capillaries
☐ Dark Spots
☐ Excessive Oil/Shine
☐ Rosacea
☐ Sun Damage
☐ Unwanted Hair
☐ Other: _____

☐ Blackheads/Whiteheads
☐ Clogged Pores
☐ Dryness
☐ Redness
☐ Scarring
☐ Uneven Skin Tone
☐ Wrinkles/Fine Lines

Have you been under the care of a dermatologist within the past year? ☐ Yes ☐ No
If yes, please explain: _____

Have you used Retin-A, Renova, AHAs or Retinal/Vitamin A products in the last three months? ☐ Yes ☐ No
If yes, please explain: _____

Have you received Botox, Restylane, or Collagen injections in the last 6 months?
☐ Yes ☐ No

By signing below, I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information.Redhead Aesthetics and medical staff reserve the right to refuse treatment of any kind for medical reasons. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the medical facility for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date
_____	_____	_____