Redhead AESTHETICS

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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

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

Are you currently taking any medications? ☐ Y es ☐ N

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 Soap
☐ Body Scrub
☐ Cleansing Cream
☐ Day Cream
☐ Eye Makeup Remover
☐ Eye Cream
☐ Exfoliants
☐ Facial Soap
☐ Facial Scrub
☐ Hand Cream
☐ Neck Cream
☐ Night Cream
☐ Skin Toner/Astringent
Other: _____

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

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?

Are you on prescription Accutane or Isotretinoin? ☐ Yes ☐ No

## Important Information

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

☐ Acne/Breakouts
☐ Blackheads/Whiteheads
☐ Broken Capillaries
☐ Clogged Pores
☐ Dark Spots
☐ Dryness
☐ Excessive Oil/Shine
☐ Redness
☐ Rosacea
☐ Scarring
☐ Sun Damage
☐ Uneven Skin Tone
☐ Unwanted Hair
☐ Wrinkles/Fine Lines
☐ Other: _____

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 _____