



Client Health Questionnaire

Date: _____
Name: _____ Birthdate: _____
Address: _____
Phone: _____
E-mail: _____
Best form of communication: Text E-mail Message
Occupation: _____
Emergency Contact _____ Best Phone Number: _____
Primary Physician: _____ Phone: _____

Health History

Do you have any allergies? _____
When exposed to the sun, do you:
 Always burn Usually burn Sometimes burn Rarely burn Very rarely burn Never burn
What is your heritage? _____
Do you use tanning beds? _____ Tanning creams or bronzers? _____ How often? _____
Do you have a history of keloid scarring? _____
Are you pregnant? _____ Trying to get pregnant? _____
Hormone Therapy? _____
Are you prone to cold sores? _____
Do you smoke? _____ How Often? _____
Do you drink alcohol? _____ How Often? _____
What skin care products are you currently using? _____
Are you currently using any Retin-A, retinol products or Hydroquinone? _____
Have you ever taken Accutane? _____ If so, when? _____
What concerns would you like addressed?
 Hair Removal Lines/Wrinkles Uneven Skin Tone/Texture
 Brown Spots/Hyperpigmentation Environmental Damage Rosacea Acne Dry Skin Scarring Skin
Laxity
How are you feeling? Dehydrated Tired Fatigued Stressed Other _____

Please list any current, recent or chronic health conditions requiring medical attention:

Please list all medications and supplements you are currently taking:

It is our goal to provide you with the best care and understanding during your visit. The information you provide us is accurate to the best of your ability and will help me deliver safe and optimum treatment results.

Client Signature: _____