Client Health History: Non-Invasive Ultrasound Health History Intake

Name: _____Date of Birth: _____

Address:_____City:_____State:_____Zip: _____

Home/Cell Phone:_____Work: _____

Email:_____ Preferred Contact: Cell____ Work ____ Email _____

Emergency contact name: _____ Phone _____

Relationship to you: _____

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

❏ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common

❏ II. Fair skinned; light hair, light eyes

❏ III. Very common skin type; fair; eye and hair color vary

❏ IV. Mediterranean Caucasian skin; medium to heavy pigmentation

❏ V. Mideastern skin; rarely sun sensitive

❏ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❏ Yes ❏ No

Areas of concern. Check all that apply:

____Abdomen ____Upper Legs "Saddle Bags" ____Lower Legs (Hamstring Area) ____Inner Thigh

____Arms (tricep side) ____Back ____Buttocks ____Calf ____Flanks "Love Handles" ____Other_____

Cosmetic History

Have you used Accutane in the past year? Yes____ No____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation?

Please List:_____

Health History

Do you form thick or raised scars from cuts or burns? Yes___ No___

Do you have any kind of tumor or cancer? Yes___ No___

Have you had chemotherapy in the past 6 months? Yes___ No_____

Have you had any abdominal surgery? Yes___ No___

Continued ⇨

Client Health History: Non-Invasive Ultrasound Health History Intake continued

Do you have any of the following conditions:

____Epilepsy ____Pregnancy and/or breastfeeding ____Autoimmune disease ____Acute inflammation

____Diabetes ____Dental implants, crowns, metal fillings ____Pacemaker or internal defibrillator

____Implanted neuro stimulators or other internal electric device

____Metal implants or other implants in the treatment area, i.e. IUD, screws, plates ____Thrombosis or phlebitis

____Kidney or liver disease

Do you have a history of Erythema Ab Igne (EAI), a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? Yes ___ No ___

Do you have any other health condition not mentioned here? Yes___ No___ If yes, please list _____

Do you have any allergies to medications, food, latex, topical products, and/or other substances? _____

_____

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Have you undergone any recent surgery or procedure? Yes___ No___

If yes, please explain_____

_____

Please list all vitamins and supplements including herbal remedies you take regularly _____

_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____

_____

Is there anything else you would like us to know? _____

_____

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 esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) _____

Client Name (Signature) _____ Date: _____

Esthetician/Technician: _____ Date: _____