Upstage Beauty
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Upstagebeauty.com

CLIENT HEALTH HISTORY FORM

Date:____/____/_____

Name:_____ Date of Birth____/____/_____

Address:_____City_____State_____Zip_____

Phone:_____ E-mail:_____

Physician:_____Phone:_____

Emergency Contact:_____ Phone_____

- Have you been under the care of a physician, dermatologist or other medical professional within the past year? Circle **YES / NO** If yes, please explain_____
- Any recent surgery, including plastic surgery? **YES / NO**
  If yes, please explain_____
- Any skin cancer? **YES / NO** If yes, please explain_____
- Have you had any piercings, tattoos, or permanent cosmetics? **YES / NO**
  If yes, where on your person?_____
- Have you ever had a body spa treatment before? **YES / NO**
  If yes, when?_____
- Have you had any of these health conditions in the past or present? (Please circle all that apply and provide additional information in the space provided)

Cancer	YES / NO	Headaches (chronic)	YES / NO
Hormone imbalance	YES / NO	Hepatitis	YES / NO
Systemic disease	YES / NO	Herpes	YES / NO
High blood pressure	YES / NO	Frequent cold sores	YES / NO
Spinal injury	YES / NO	Immune disorders	YES / NO
Thyroid condition	YES / NO	HIV/AIDS	YES / NO
Hysterectomy	YES / NO	Lupus	YES / NO
Diabetes	YES / NO	Metal bone pins or plates	YES / NO
Heart problems	YES / NO	Phlebitis, blood clots, poor circulation	YES / NO
Varicose veins	YES / NO	Blood clotting abnormalities	YES / NO
Arthritis	YES / NO	Psychological treatment	YES / NO

Asthma	YES / NO	Insomnia	YES / NO
Eczema	YES / NO	Keloid scarring	YES / NO
Epilepsy	YES / NO	Skin disease/skin lesions	YES / NO
Seizure disorder	YES / NO	Any active infection	YES / NO
Fever blisters	YES / NO		

Additional Information_____

_____

- Has your physician discussed concerns about raising your body temperature? **YES / NO** If Yes, please explain_____
- Do you Smoke? **YES / NO**
- Do you follow a restricted diet? **YES / NO** If yes, please explain_____
- Do you follow a regular exercise program? **YES / NO**
- What is your stress level? **HIGH MEDIUM LOW**
- List any medications you take regularly_____
- List any over the counter medications (including vitamins, herbal supplements, aspirin etc.) you take regularly: _____
- Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products? **YES / NO** If yes, describe_____
- Have you used any of these products in the last 3 months? **YES / NO**
- Have you used an acne medication? **YES / NO** If yes, when_____ Which drug?_____
- Do you form thick or raised scars from cuts or burns? **YES / NO**
- Do you have hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? **YES / NO** If yes, describe_____
- List your daily consumption of: Water_____Caffeine_____Alcohol_____
- Do you experience any problems sleeping? **YES / NO**
- How many hours do you typically sleep each night? _____
- Do you wear contact lenses? **YES / NO**
- Have you been exposed to the sun or use a tanning bed? ___infrequently___frequently___regularly
- Do you have any metal implants or wear a pacemaker? **YES / NO**
- Have you ever experienced claustrophobia? **YES / NO**
- Do you suffer from sinus problems? **YES / NO**

- Have you ever had an adverse reaction to any of the following?

  Rash Irritation Peeling Sun Sensitivity Breakout

  Explain:_____

- Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

  Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHA's Fragrance

  Shellfish Latex Drugs Other:_____

  Explain:_____

Female Clients Only:

- Are you taking oral contraceptives? **YES / NO** If yes, please specify_____
- Any recent changes to or from your contraceptive treatment? **YES / NO** If so, what and when?_____
- Are you pregnant or trying to become pregnant? **YES / NO**
- Are you lactating? **YES / NO**
- Any menopause problems? **YES / NO** If yes, please specify_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindication and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here a voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature:_____Date:_____/_____/_____