Majestic Beauty Spa PLLC

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name____ Today's Date_________________

Date of Birth_____________Age_________Occupation____

Home Address_______________________ City_______________State______Zip Code______________

Home Phone_______________ Work Phone_______________ Email______________________

Emergency Contact Name and Phone____

How were you referred to us? ____

Do you regularly sun bathe or use tanning salons?__________How often?___________________

MEDICAL HISTORY

Do you have any of the following medical conditions? (Please check all that apply)

❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis ❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions ❑Seizure disorder ❑Hepatitis ❑Hormone imbalance ❑Thyroid imbalance ❑Blood clotting abnormalities ❑Any active infection

Are you currently under the care of a physician? ❑Yes ❑ No

If yes, for what:____

Do you have any other health problems or medical conditions? Please list: ______________________

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Have you ever had an allergic reaction? (List any and all reactions you experienced) ❑None ❑Food ❑Animal Protein ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others:____

MEDICATIONS

What prescription medications or herbal supplements are you presently taking?

❑ Birth control pills ❑ Hormones ❑ RetinA ❑ Others (It is required that you list all of them):

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HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature____ Date:________________