HEALTH HISTORY ASSESSMENT

Name: _____ Today's Date: _____
Address: _____
Home #: _____ Work #: _____ Cell #: _____
E-mail: _____ Referred by: _____ Date of Birth/Age: _____

HORMONE-RELATED QUESTIONS
What age did hair growth begin?_____
Regular menstrual cycle _____

Circle all that apply:
Fertility problems
Weight gain/ loss
Acne
Hormone/ Endocrine disorder
Family history of similar hair growth
Hysterectomy or Menopause
Scalp hair loss
Irregular menses
Eating disorder
PCOS
Date of last physical:_____
Current medications:_____
_____
_____

Circle all to be treated:
Upper/Lower Lip
Hairline
Cheeks
Sideburns/ Ears
Chin/Neck
Nape of Neck
Shoulders
Chest/Breasts
Arms
Underarms
Back
Upper/Lower Abdomen
Hands/ Fingers/ Feet/ Toes
Bikini Area
Legs (upper/lower)
Other_____

PREVIOUS METHODS OF HAIR REMOVAL

Circle all that apply:
Shaving/Clipping
Depilatories/ Waxing
Tweezing
Bleaching
Laser
Electrolysis
How often?_____

Skin reactions to previous hair removal methods:
Circle all that apply:
Redness/ Swelling
Ingrown Hair/ Pimples
Pigmentation/ No skin reaction
Other_____

GENERAL HEALTH QUESTIONS
Circle all conditions, past & present that apply:

Acne
Allergy to Aspirin
Allergy to Latex
Allergy to Metal
Body Piercings
Breathing Problems
Cancer
Cardiovascular disease
Cold Sores/ Warts/ Herpes
Diabetes
Healing Problems/ Keloids
Hepatitis
High Blood Pressure
HIV
Metal Implants/ Pacemaker
Pregnancy
Skin Tags
TB

Other conditions or allergies:_____

ACKNOWLEDGMENT OF INFORMATION
I understand health history information is important to the Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge and I agree to update my health history assessment whenever there are changes.I understand that a series of treatments is necessary to achieve permanent hair removal based on my previous temporary methods of hair removal, the science of electrology, and my individual physiological factors. I have been advised of the post-treatment healing process; the possible risks related to treatment, I agree to follow all aftercare instructions and to notify the Electrologist of any concerns or difficulty in healing.

_____
Client signature Parent/guardian signature for minor Date