chapter

AESTHETIC STUDIO

Skin/Health Assessment

NAME _____ DATE _____

◯ Y ◯ N Do you have any allergies? Please list allergy and your reaction: _____

◯ Y ◯ N Do you have any medical conditions? Please list: _____

◯ Y ◯ N Are you taking any medications, vitamins and/or supplements? Please list: _____

◯ Y ◯ N Have you ever had any surgeries? Please list: _____

◯ Y ◯ N Have you ever had any type of cancer?
If yes, please explain when diagnosed and what kind: _____

◯ Y ◯ N Are you currently being treated for cancer?
If yes, please explain the type of treatment you are receiving: _____

◯ Y ◯ N Do you have, or have you had, unusual skin lesions?
If yes, please explain: _____

◯ Y ◯ N When you have a cut, scratch or sore, does your skin color have a tendency to hyper- or hypo- pigment?

◯ Y ◯ N Do you have a history of Keloid scarring (white, raised, hardened scars)?

◯ Y ◯ N Do you have a history of skin disorders such as: eczema, psoriasis, rashes?

◯ Y ◯ N Do you bruise easily or heal slowly?

◯ Y ◯ N Are you a smoker?

◯ Y ◯ N Do you have a pacemaker?

◯ Y ◯ N Are you under the care of a dermatologist or physician? Please explain: _____

◯ Y ◯ N Are you pregnant? ◯ Y ◯ N Attempting pregnancy? ◯ Y ◯ N Breastfeeding?

◯ Y ◯ N Do you have a history of cold sores?

◯ Y ◯ N Have you used Accutane in the past 6 months?

◯ Y ◯ N Do you use tanning beds? How often?: _____ ◯ Y ◯ N Do you use sunscreen?

_____ SIGNATURE _____ DATE

CLINIC STAFF COMPLETE

_____ DATE

THE NON-CLIENT CONDITION SPECIFIC PROTOCOL IS AUTHORIZED:

☐ Authorized, NO exceptions

☐ Authorized, WITH exceptions:

_____ RN

_____ MEDICAL DIRECTOR