Z Medi Spa

CLIENT HEALTH HISTORY

Fill in this form to the best of your ability; please make notes on the back as this is for informational purposes. This form is merely a beginning of our information gathering process. When you make your appointment to meet with a Personal Image Consultant, bring this form (and the Condition Reviews) with you. as your concerns will be addressed in detail during your 30 minute consultation.

TODAY'S DATE_____ **REFERAL** _____

NAME/LAST_____**FIRST**_____**M**____**F**____ **DOB (OPTIONAL)**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

PHONES/HOME _____ **WORK** _____**CELL** _____

EMAIL ADDRESS _____ **FAX NUMBER** _____

HEIGHT _____**FT**_____**IN** **WEIGHT** _____ **OCCUPATION**_____

□ YES □ NO Are you currently taking any medications?_____
□ YES □ NO Do you have allergies to any medications?_____
□ YES □ NO Do you have any allergies?_____
□ YES □ NO Have you ever suffered a severe allergic reaction, explain?_____
□ YES □ NO Have you ever had an allergic reaction to local anesthesia, explain?_____
□ YES □ NO Do you smoke? How many years? _____ How much_____/day?
□ YES □ NO Have you ever smoked? How many years? _____ How much_____/day?
□ YES □ NO Have you ever had surgery? List_____
□ YES □ NO Have you ever had cosmetic surgery? List_____
□ YES □ NO Do you have cardiovascular or heart disease?
□ YES □ NO Do you have diabetes?
□ YES □ NO Do you have epilepsy?
□ YES □ NO Is there any incidence of cancer in your family?_____
□ YES □ NO Do you have hepatitis?
□ YES □ NO Do you have migraine headaches?
□ YES □ NO Do you have asthma/hay fever?
□ YES □ NO Do you have high/low blood pressure?_____
□ YES □ NO Have you ever had herpes, cold sores, fever blisters, keloids, hives?_____
□ YES □ NO Are you currently under a physician's care? Explain_____
□ YES □ NO Do you have venereal disease, HIV, AIDS?_____
□ YES □ NO Do you have thyroid or kidney problems?_____
□ YES □ NO Do you have emphysema?
□ YES □ NO Do you have incidents of fainting or dizzy spells?_____
□ YES □ NO Do you have any drug addictions?
□ YES □ NO Do you have anemia?
□ YES □ NO Do you have arthritis?

QUESTIONS RELATING TO SKIN/SKIN CARE

□ YES □ NO Is your family prone to vascular blemishes? Spider Veins_____ Varicose leg veins_____ cherry anginoma_____ broken facial capillaries_____ Upper body capillaries_____?
□ YES □ NO Have you ever visited a dermatologist, plastic surgeon, cosmetic dentist, or other skin care therapist?_List_____
□ YES □ NO Have you ever used Retin A or a similar product?_____
□ YES □ NO Do you use skin products such as moisturizer, cleanser? Explain_____
□ YES □ NO Do you suntan? Do you use sunscreen?_____

□ YES □ NO Do you follow a diet and watch your caloric intake?
□ YES □ NO Do you follow an exercise routine?

Is your skin: □ Dry □ Oily □ Normal □ Combination

Are you □ Fair □ Olive □ Asian □ Hispanic □ Native American □ African American

What are you concerns with your skin?_____

How much liquid do you drink /day?_____

What vitamins/minerals do you take regularly?_____

Comments_____

I have completed the Health History questionnaire. I am in good physical condition and mental state. I have no physical restrictions, conditions, disabilities or ailments that are not noted here.

Signature_____

Printed Name_____

NOTES: