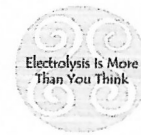




HEALTH HISTORY ASSESSMENT



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