Client Health History:
Advanced Exfoliation Treatment - Health History Intake

Name: _____ Date of Birth: _____

Are you over the age of 18 years? Yes___ No___

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation? Please List:_____

Are you currently using, or have you used in the past year, any of the following?

Isotretinoin (Accutane)	Adapalene (Differin)	Tretinoin (Retinoic Acid)	Acyclovir
Hydroquinone	Azelaic Acid	Glycolic Acid	Lactic Acid
Salicylic Acid	Spironolactone		

Have you ever had any of the following injectables or implants?

Botox	Juvederm	Radiesse	Restylane
Perlane	Silicone	Collagen	Sculptra
Dysport	Other: _____		

If yes, when? _____ What body area(s)? _____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes ___ No___ If yes, please describe _____

Do you form thick or raised scars from cuts or burns? Yes___ No___

Have you had any laser resurfacing treatments in the past six weeks? Yes ___ No ___ If yes, when? _____

Have you used any of the following hair removal methods in the past six weeks?

Shaving	Waxing	Electrolysis
Tweezing		
Threading	Depilatories	

If yes, when? _____ What body area(s)? _____

Have you had chemotherapy in the past 6 months? Yes___ No_____

Do you have any allergies to medications, food, latex, topical products, and/or other substances? Yes___ No___
If yes, please describe_____

Do you have any of the following conditions?

Autoimmune disease	Herpes Simplex (Cold Sore)	Diabetes	Thrombosis
Phlebitis	Varicose veins	HIV	Eczema
Infections	Lupus	Cancer	Psoriasis
Dermatis	History of skin disorders	Pregnancy and/or breastfeeding	

Do you have a history of Erythema Ab Igne (EAI), a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? Yes ___ No ___

Do you have any other health condition(s) not mentioned here? Yes___ No___
If yes, please list:_____

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Have you undergone any recent surgery? Yes___ No___ If yes, please explain:
_____

Please list all vitamins and supplements including herbal remedies you take regularly _____
_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____
_____

Is there anything else you would like us to know? _____
_____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved by Sweet Life Skincare, LLC. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost. I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today. I hereby release Sweet Life Skincare, LLC and the esthetician harmless from any liability that may result from this treatment.

***Caution**: We cannot perform hydrodermabrasion, dermaplaning, facial infusion, and/or chemical peel applications if any of the following conditions exist: Severe health conditions or any of the following contraindications, any contagious disease, any drug causing sun sensitivity, any drug or application causing thinning of skin, blood transmitted diseases, any anticoagulants medications, or if the conditions are unknown to you, consult a physician.*

Client Name (Printed) _____
Client Name (Signature) _____Date: _____
Esthetician/Technician: _____Date: _____