CLEAR FORM

PRINT

Confidential Case History

General Information

Date: __ / __ / ____ (mm / dd / yyyy)

Name: Last - _____ , First - _____

Address: _____ City: _____ State: __ Zip: _____

Occupation: _____

Phone: Area code: ___ Prefix: ___ Number: ____

How were you referred: _____

Are you under a doctor's Care NO ☐ YES ☐

If Yes,

Physician's Name: _____

General Medical History: Mark Appropriately and Explain

	No	Yes		No	Yes
Acne	☐	☐			
Allergies	☐	☐	Heart Condition	☐	☐
Canker Sores	☐	☐	Hemophilia	☐	☐
Carcinoma	☐	☐	Hepatitis	☐	☐
Cold Sores	☐	☐	H.I.V	☐	☐
Contact Lenses	☐	☐	status_____		
Dermatitis/Eczema	☐	☐	Keloid Scars	☐	☐
Diabetes	☐	☐	Metal Pins	☐	☐
Genital Herpes	☐	☐	Moles	☐	☐
Hearing Aid	☐	☐	Pacemaker	☐	☐

Other conditions not listed _____

Cisgender Female	No	Yes
	☐	☐

If yes

Medical Information:	No	Yes
In Menopause?	☐	☐
Post Menopause?	☐	☐
Regular Periods?	☐	☐
Hormonal Imbalance?	☐	☐
IUD?	☐	☐
PCOS?	☐	☐
Pregnant?	☐	☐

Are you currently taking any of the following?

	NO	YES
Birth Control Pills?	☐	☐
Hormones?	☐	☐
Other Medication?	☐	☐

please specify _____

_____

_____

_____

_____

_____

Desired Treatment Areas: Check all that apply

Chin..... ☐
Upper Lip..... ☐
Sides of Face..... ☐
Eyebrows..... ☐
Nose..... ☐
Ears..... ☐
Breasts..... ☐
Chest ..... ☐
Back..... ☐
Hairline..... ☐

Nape of neck..... ☐
Hands / Fingers..... ☐
Abdomen..... ☐
Bikini Line..... ☐
Full Groin..... ☐
Legs..... ☐
Thighs..... ☐
Arms / Underarms.. ☐
Feet / Toes..... ☐
Scalp..... ☐

Other: _____

Previous Treatment: None ☐ Thermolysis ☐ Galvanic ☐ Blend ☐ Laser ☐ Unknown ☐

Former Methods of Hair Removal:

Razor ☐ Tweezers ☐ Depilatory ☐ Wax ☐ Other ☐

Area describe, _____

How Long _____

How Often _____

I acknowledge that the information provided by me is accurate to the best of my knowledge, and at present conditions of the areas to be treated are as stated on this form. I understand that repeated treatments are necessary for permanent results. If I am unable to keep my appointment, I will give my electrologist at least 24 hours notice, if not I will be charged 50% of the fee for the scheduled appointment.

Signature: _____ Date:_____

Printed Name: _____

Official Use Only

Treatment Area Assessment	Initial Skin Appearance	Condition of Growth
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

Additional observations / Skin conditions _____

_____

_____