

# 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              | <input type="checkbox"/> | <input type="checkbox"/> |                 |                          |                          |
| Allergies         | <input type="checkbox"/> | <input type="checkbox"/> | Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Canker Sores      | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia      | <input type="checkbox"/> | <input type="checkbox"/> |
| Carcinoma         | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis       | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Sores        | <input type="checkbox"/> | <input type="checkbox"/> | H.I.V           | <input type="checkbox"/> | <input type="checkbox"/> |
| Contact Lenses    | <input type="checkbox"/> | <input type="checkbox"/> | status_____     |                          |                          |
| Dermatitis/Eczema | <input type="checkbox"/> | <input type="checkbox"/> | Keloid Scars    | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes          | <input type="checkbox"/> | <input type="checkbox"/> | Metal Pins      | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital Herpes    | <input type="checkbox"/> | <input type="checkbox"/> | Moles           | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Aid       | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker       | <input type="checkbox"/> | <input type="checkbox"/> |

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?

Birth Control Pills? NO YES

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Initial Skin Appearance

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Condition of Growth

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Additional observations / Skin conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_