**PATIENT MEDICAL HISTORY FOR SKINCARE TREATMENT**

**Please check the following that apply:**
Heart Condition:___ Keloids/Irregular Scarring:___ Diabetes:___ Pregnant/Breast Feeding:_____
Tattoos/Perm Makeup:___ Sun Sensitivity:___ Accutane use: (if yes, when?)_____
Contact Lenses:_____ Hormone Replacement Therapy:_____ Thyroid Disorders:_____
Latex Allergy:_____ Claustrophobia:_____ Skin Cancer:_____ Varicose Veins:_____
Cold Sores/Herpes: (check if you have ever had in your lifetime)_____

List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, asprin, etc.):

_____

Do any of these medications have a sunlight exposure warning? (Retin-A, Glyolic, Latic Acid, Hydroquinone)_____

Allergies (drug/food/environmental):_____

**Skin Background:**

| | |
|---|---|
| Are you Currently sunburned? | ____ Yes ____ No |
| Do you use tanning beds/tan regularly? | ____ Yes ____ No |
| Do you use sunless tanning solutions? | ____ Yes ____ No |
| Do you use sunscreen on a regular base? | ____ Yes ____ No |
| Have you had any facial treatments in the past three months? | ____ Yes ____ No |

Have you had any of the following in the last 14 days? (check all that apply)
___Facial cosmetic surgery ___Botox injections ___Collagen injections ___Waxing ___Fillers
__Light treatments __Laser resurfacing __Microdermabrasion __Extractions __Permanent cosmetics
___Chemical exfoliation (peels) ___Laser hair removal ___Hair treatments (perms, color, etc.)

What skincare products/regimen are you currently using at home? _____

**Reason for Today's Visit:**
Check services of interest: ___Microdermabrasion ___Dermaplane ___Chemical Peel
___Facial ___Waxing ___Other:_____

List areas of concern:_____

What are your expectations/goals with the treatments?_____

I understand that some skin conditions will require more than one treatment and home care products to achieve the desired results. Results cannot be guaranteed due to individual skin type(s) and condition(s).

I understand that it is my responsibility to notify my skin care technician if any of the above information changes.

I certify that the above medical history information is accurate and correct:

Patient Signature:_____ Date:_____

DR/Tech Signature:_____ Date:_____

**SATIN SMOOTH CLIENT RECORD CARD**

Name: _____

Street Address:_____

City:_____

State/Zip:_____

Birthday:_____

How often do you have waxing done?_____

Have you ever had a reaction to a waxing service?_____

Primary Phone: (_____)_____

Secondary Phone: (_____)_____

Email:_____@_____

Preferred Method of Contact:
(*Mainly for appointment confirmation*)
☐ Text Message ☐ Phone Call ☐ Email

Have you been or will you be in the sun (or tanning bed) within 24 hours of this treatment?_____

THE LEGAL STUFF

I have been advised that the service(s) provided to me by this salon could have unfavorable results including, but not limited to: allergic reaction, irritation, burning, redness, soreness, etc. I am aware that certain medications and over-the-counter products can significantly increase the risk of injury when combined with skin care services. I understand that this salon does not recommend skin care services for customers using Retin-A©, Accutane©, products containing Alpha Hydroxy©, or any other skin thinning treatments. I hereby confirm that I am not using any medication that may cause or contribute to any such injury/reaction, and I will advise my stylist/esthetician should I use any such medication in the future. I understand that there are often inherent risks associated with skin care services, and I agree that as a condition of providing these services on an ongoing basis, I will not hold Salon Bella Inc or the shopping center in which this salon is located, or any of their employees responsible should there be any unfavorable outcome or result.

Signature:_____ Date:_____

Technician use only:

| Date | Type of service | Type of wax used | Cost |
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