the nature of beauty
the best in organic and natural beauty

HEALTH HISTORY

Name _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Work _____ Home _____

We send out appointment reminders by email. Email: _____

Check all that apply to you now or in the past:

- ☐Cancer
- ☐HIV/AIDS
- ☐Hepatitis
- ☐Diabetes
- ☐A Pacemaker
- ☐Pins or metals in your body
- ☐Dental implants
- ☐Seizure disorders/Epilepsy
- ☐High Blood Pressure
- ☐Bleeding disorders/Hemophelia
- ☐Frequent Cold Sores
- ☐Fainting/Narcolepsy
- ☐Psoriasis
- ☐Keloid scars
- ☐Severe histamine reaction
- ☐Clausterphobia
- ☐Thyroid imbalance
- ☐Hormone imbalance
- ☐Polycystic Ovaries
- ☐Endometriosis

Do you have any other health problems? ☐yes ☐no
If yes, please list:
_____

Are you currently under the care of a physician? ☐yes ☐no
If yes, for what?
_____

Are you currently under the care of a dermatologist? ☐yes ☐no
If yes, for what?
_____

Do you have any allergies to:

- ☐Latex products
- ☐Aspirin
- ☐Drugs
- ☐Skin bleaching agents
- ☐Lidocaine
- ☐Citrus Fruits

If yes, please list:
_____

Medications: (list on back if you need more room)

List any oral medications/conditions that require you to take meds including steroids, antidepressants, mood altering drugs or anticoagulants that thin the blood or interfere with blood clotting:
_____
_____

List any herbal supplements or vitamins you use regularly:
_____

Have you ever used...

	If yes, how long ago?
☐Accutane	_____
☐Retin-A	_____
☐Hydroquinone	_____

Have you ever had...

	If yes, how long ago?
☐Chemical Peels	_____
☐Microdermabrasion	_____
☐Botox	_____
☐Fillers (i.e. Restylane, Radiesse, Collagen)	_____
☐Facial Laser Resurfacing	_____
☐Facial Cosmetic Surgery	_____
☐Permanent Makeup	_____

Do you...

Smoke	☐yes	☐no
Visit Tanning Salons	☐yes	☐no
Consume more than 1-2 alcohol beverages daily	☐yes	☐no
Consume more than 8oz of caffeine daily	☐yes	☐no
Drink at least 8 glasses of water daily	☐yes	☐no
Wear UVA/UVB Sunscreen daily	☐yes	☐no
Excercise regularly	☐yes	☐no
Get at least 7 hours of sleep per night	☐yes	☐no
Rate your stress level from 1-10	_____	

Which conditions would you like to improve?

- ☐Brown spots (hyperpigmentation)
- ☐Sun Damage
- ☐Lines & Wrinkles
- ☐Rough Texture
- ☐Dryness/Dehydration
- ☐Acne
- ☐Acne Scarring
- ☐Surgical Scars
- ☐Enlarged Pores
- ☐Redness or flushing

Other:
_____

Please list all cleansers, moisturizers etc. that you are using:
_____

Please list all foundations, concealers and powders you are using:
_____

Female patients only:

Are you pregnant or breastfeeding?	☐yes	☐no
Are you trying to become pregnant?	☐yes	☐no
Are you taking birth control or hormones?	☐yes	☐no

Are there other services you'd like more information about?

- ☐Botox or Fillers
- ☐Hyfrecator
- ☐Microneedling
- ☐Skin Care Products
- ☐Makeup
- ☐Permanent Makeup

By signing this form, I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist,or tattoo artist of my current medical or health conditions and to update this history as needed. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

CLIENT SIGNATURE _____ DATE _____