CONFIDENTIAL CASE HISTORY/HEALTH ASSESSMENT

NAME_____
ADDRESS_____
CITY_____STATE_____ZIP_____
PHONE: HOME:_____MOBILE:_____
E-MAIL_____ D.O.B._____

REFERRED BY: ☐ ELECTROLOGIST_____ ☐ RELATIVE_____
☐ DOCTOR_____ ☐ FRIEND_____
☐ ONLINE (YP.COM, YELP, GOOGLE, FACEBOOK, ETC)_____

MEDICATIONS_____
PREVIOUS ELECTROLOGY TREATMENT? ☐YES ☐NO
DATE OF TREATMENT: INITIAL_____ LAST_____
FREQUENCY:_____ LENGTH OF TREATMENT:_____

TEMPORARY REMOVAL HOW OFTEN?

TWEEZERS	☐ YES ☐ NO	_____	WAX	☐ YES ☐ NO	_____
DEPILATORY	☐ YES ☐ NO	_____	RAZOR	☐ YES ☐ NO	_____
CLIPPING	☐ YES ☐ NO	_____	OTHER	☐ YES ☐ NO	_____

AREAS REQUESTED TO BE TREATED

☐ CHIN	☐ ARM	☐ TOES
☐ UPPER LIP	☐ FINGERS	☐ EXTERNAL EAR LOBE
☐ BROW	☐ ABDOMEN	☐ EXTERNAL NOSE
☐ HAIRLINE	☐ BIKINI LINE	☐ BACK
☐ BREAST	☐ LEGS	☐ OTHER
☐ UNDERARM	☐ FEET	_____

GENERAL HEALTH

ALLERGIES	☐ YES ☐ NO	MITRAL PROLAPSE	☐ YES ☐ NO
HEART CONDITION	☐ YES ☐ NO	HERPES SIMPLEX	☐ YES ☐ NO
HEPATITUS	☐ YES ☐ NO	CARCINOMA	☐ YES ☐ NO
HEMOPHILIA	☐ YES ☐ NO	BLOOD PRESSURE	☐ YES ☐ NO
HODGKINS DISEASE	☐ YES ☐ NO	PACEMAKER	☐ YES ☐ NO
EPILEPSY	☐ YES ☐ NO	METAL IMPLANT	☐ YES ☐ NO
SURGERY	☐ YES ☐ NO	INFECTIOUS	☐ YES ☐ NO
DIABETES	☐ YES ☐ NO	BLOOD DISEASE	

ENDOCRINE SYSTEM

GLANDULAR DYSFUNCTION		PREGNANCY	☐ YES ☐ NO
THYROID	☐ YES ☐ NO	HYSTERECTOMY	☐ YES ☐ NO
PITUITARY	☐ YES ☐ NO	BIRTH CONTROL	☐ YES ☐ NO
ADRENAL	☐ YES ☐ NO	MENOPAUSE	☐ YES ☐ NO
OVARIAN	☐ YES ☐ NO	REGUALR PERIODS	☐ YES ☐ NO

SKIN DISORDERS/TREATMENT

ACNE	☐ YES ☐ NO	MELANOMA	☐ YES ☐ NO
ECZEMA	☐ YES ☐ NO	RETINA	☐ YES ☐ NO
HIVES	☐ YES ☐ NO	CHEMICAL PEEL	☐ YES ☐ NO
FOLLICULITIS	☐ YES ☐ NO	LASER	☐ YES ☐ NO
KELOIDS	☐ YES ☐ NO	COLLAGEN (INJECTABLE)	☐ YES ☐ NO
MICRODERMABRASION	☐ YES ☐ NO	IF YES: AREA_____	DATE_____
PSORIASIS	☐ YES ☐ NO	OTHER:_____	

STATEMENT OF PRACTICE: An electrologist may provide a prognosis in regard to permanent hair removal, but does not provide medical diagnosis. The information I have provided is true and complete to the best of my knowledge and I agree to inform my electrolysis of changed. I have received a through consultation and feel I have made an informed decision to proceed with my electrology treatment. I understand permanent hair removal requires a series of treatments over a period of time and have been advices of the recommended aftercare procedures. Signature_____ Date_____

ELECTROLOGIST REMARKS

HEATH ASSESSMENT-CLENT COMMENT/DETAIL_____
_____
_____
_____

SKIN CONDITION: PRETREATMENT_____POST TREATMENT_____
HAIR TYPE_____AREAS TREATED_____
SETTING/MODALITY_____TOLERANCE_____AFTER CARE_____
PROGNOSIS_____
COMMENT_____