BodiSculpting
SPECIALISTS

Personal History:

Client Name_____DOB:____/_____/_____Age_____

Today's Date_____Occupation_____

Home Address_____

City_____ State_____Zip_____

Phone_____Email_____

Can we text for appointments? YES / NO Cell Carrier_____

Emergency Contact and Phone_____

How were you referred to us?_____

Circle any concerns so we can customize your plan.

Skin Laxity Body Body Contouring Cellulite Skin Laxity Face Skin Discoloration

Past or Current Personal Medical History: (please circle all that apply)

Anemia	Cold Sores	Hepatitis B or C
Arthritis	Diabetes	High Blood Pressure
Artificial Joint	Dialysis	HIV/AIDS
Autoimmune Disease	Depression	Multiple Sclerosis
Bleeding Disorder	Fibromyalgia	Seizure Disorder Blood Clots
Heart Disease	Thyroid Disorder	Cancer
Breast Cancer	Pacemaker	Metal Implants
Blood Clots	Herpes Simplex	Raynaud's Disease

Other_____
_____
_____

Please complete the back of the page and sign.

Past or Current Personal Skin History: (please circle all that apply)

Undiagnosed Skin Lesions	Skin Infection	Psoriasis
Actinic Keratosis	Squamous Cell Cancer	Shingles
Basal Cell Skin Cancer	Melanoma	Keloid Scars
Lupus	Pigment Disorder	Eczema

Are you currently under the care of a Physician? Y_____ N_____
If Yes, for what?_____
_____
Are you currently under the care of a Dermatologist? Y_____ N_____

Have you ever been under the care of a Dermatologists or Plastic Surgeon? Y_____ N_____
If yes please explain: _____

Do you have any other health problems or medical Conditions?_____
_____
Past surgeries:_____

Medications

What oral medications are you currently taking?_____
_____
Are you on any mood altering or anti-depressant medication?_____
Have you ever used Accutane? Y____ N_____ Last use?_____
What topical medications or creams are you currently using?_____
What herbal supplements are you currently using?_____

Have you ever had allergic reaction to any of the following? (please circle all that apply)

Food Latex Aspirin Lidocaine Hydrocortisone Hydroquione

Other_____

I certify that the preceding medical, personal & skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, medical assistant, nurse or doctor of my current medical or health conditions and to update history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature:_____Date:_____
Witness:_____ Date:_____