

Date \_\_\_\_\_

# CASE HISTORY / HEALTH ASSESSMENT

## GENERAL HEALTH

Name \_\_\_\_\_

Name \_\_\_\_\_ Name preference \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse \_\_\_\_\_ E-Mail \_\_\_\_\_

Are spouse, co-workers, friends aware of treatments? \_\_\_\_\_

Physician: Primary \_\_\_\_\_ Dermatologist \_\_\_\_\_

Endocrinologist \_\_\_\_\_ Referred by \_\_\_\_\_

Currently undergoing medical treatment for \_\_\_\_\_

Medications ( oral & ointments / creams)	Purpose of Medications
_____	_____
_____	_____
_____	_____

Previous electrology treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Over what period of time? \_\_\_\_\_ Approximate date of last visit? \_\_\_\_\_

Hereditary hair problems? Yes \_\_\_\_\_ No \_\_\_\_\_ Age excess hair first noticed? \_\_\_\_\_

Temporary methods of hair removal used? \_\_\_\_\_

Frequency? \_\_\_\_\_ Last Used? \_\_\_\_\_

### AREAS REQUESTED TO BE TREATED

Chin \_\_\_\_\_ Upper Lip \_\_\_\_\_ EyeBrow \_\_\_\_\_ Hairline \_\_\_\_\_ Breast \_\_\_\_\_ Underarm \_\_\_\_\_

Arm \_\_\_\_\_ Hand / Fingers \_\_\_\_\_ Abdomen \_\_\_\_\_ Bikini Line \_\_\_\_\_ Thighs / Legs \_\_\_\_\_

Feet / Toes \_\_\_\_\_ Cheeks / Sideburns \_\_\_\_\_ Ears \_\_\_\_\_ External Nose \_\_\_\_\_ Back \_\_\_\_\_

Chest \_\_\_\_\_ Other \_\_\_\_\_

**STATEMENT OF PRACTICE** The information I have provided is true and complete to the best of my knowledge and I agree to inform my electrologist of any changes. I have received a thorough 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 advised of the recommended aftercare procedures.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Laser Treatment NO YES

Retin-A NO YES

Keloids NO YES

Skin Sensitivity / Allergies NO YES

Fever Blisters / Cold Sores NO YES

Recent collagen injections, \_\_\_\_\_

Chemical peels, or Dermabrasion NO YES

Allergies NO YES

Heart Condition NO YES

Rheumatic Fever NO YES

Mitral Valve prolapse / Heart Murmurs NO YES

Pacemaker NO YES

Diabetes NO YES

Hepatitis NO YES

HIV Positive NO YES

Epilepsy / Seizures NO YES

High Blood Pressure NO YES

Contacts (Hard or Soft) NO YES

Metal Implants / Screws / Plates NO YES

Malignancy / Cancer NO YES

Thyroid Problems NO YES

(Women Only)

Polycystic Ovarian Disease NO YES

IUD NO YES

Pregnant NO YES

Plans to become pregnant NO YES

Infertility NO YES

Hysterectomy NO YES

Birth Control Pills NO YES

Menopause NO YES

Regular Periods NO YES

Other skin disorders \_\_\_\_\_

\_\_\_\_\_

Other health concerns \_\_\_\_\_

\_\_\_\_\_