

CONFIDENTIAL CASE HISTORY

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ EXT. _____

AGE _____ BIRTH DATE _____ REFERENCE _____

PHYSICIAN _____ PHONE _____

DATE _____

PREVIOUS TREATMENTS: NONE THERMOLYSIS GALVANIC
 HOW LONG _____ AREA _____

RAZOR _____

TWEEZERS _____

DEPILATORY _____

WAX _____

OTHER _____

CONDITION OF GROWTH _____

CONDITION OF SKIN _____

ARE YOU UNDER DOCTORS CARE? _____

MEDICATION _____

ILLNESS OR DEFECT _____

I acknowledge that all information contributed by me is accurate to the best of my knowledge, and that the present condition of the areas to be treated is as stated on this record. I understand that repeated treatments are necessary.

MEDICAL HISTORY: HAVE YOU HAD? EXPLANATION.

AIDS - ARC NO YES

ALLERGIES NO YES

BIRTH CONTROL PILLS NO YES

BRUISE EASY NO YES

CONTACTS LENS NO YES

DIABETES NO YES

HEART CONDITION NO YES

HEMOPHILIA NO YES

HEPATITIS NO YES

HERPES SIMPLEX NO YES

HIGH BLOOD PRESSURE NO YES

HYSTERECTOMY NO YES

KELOID SCARS NO YES

METAL IN BODY NO YES

PACEMAKER NO YES

PREGNANT NO YES

REGULAR PERIODS/MENOPAUSE NO YES

SIGNATURE _____ DATE _____

TYPE OF HAIR: SHALLOW (S) NORMAL (N) DEEP (D) DISTORTED (X)

UPPER LIP _____ CHIN _____ EYEBROWS _____ ARM _____

LEG _____ UNDERARM _____ OTHER _____

SKIN REACTION _____

PATIENT REACTION _____

AFTER CARE MEDICATION _____

SENSITIVITY _____

COMMENTS _____