CONFIDENTIAL HEALTH HISTORY

C.A.T. skin assessment system

Name: _____ Date Of Birth: _____

Address: _____

Preferred Phone: _____ Secondary Phone: _____

Email: _____ Occupation: _____

Referred by: ❑ Friend _____ ❑ Walk by ❑ Internet search ❑ Social media

❑ Other _____

All information provided is voluntary. It will be kept confidential and secure. This information is used to determine contraindications to treatment, factors that can impact skin health and to provide customized skin health program recommendations.

Health

List any medications that you take regularly: _____

Female Clients Only

Are you taking oral contraceptives? ❑No ❑Yes Are you pregnant or trying to become pregnant? ❑No ❑Yes

Are you in perimenopause/menopause? ❑No ❑Yes Symptoms?_____

Do you have any of these health conditions? Please check all that apply. =MD permission for treatment

		Injuries: _____			Arthritis
Rx		Cancer (chemotherapy/radiation)			High blood pressure
		Liver or kidney problems			Thyroid condition
		Frequent cold sores			Metal pins or plates
Rx		Autoimmune disease			Diabetes/prediabetes
Rx		Skin disease, lesions, or warts			PCOS/ovarian cysts
Rx		Any active infection			Varicose veins
		Epilepsy/seizures			Fibromyalgia/CFS
		Phlebitis, blood clots, poor circulation			Asthma/allergies
		Heart problems			Glaucoma

Have you ever had an allergic reaction to the following? Please check all that apply.

❑Cosmetics ❑Food ❑Animals ❑Sunscreens ❑Iodine

❑Pollen ❑Alpha hydroxy acids ❑Fragrance ❑Shellfish ❑Latex

Lifestyle

Diet

How many days a week do you consume: Processed foods___ Broiled/grilled foods___ Baked goods___ Fruits___ Vegetables___ Vitamin D3___ Fish oil supplement___ Multivitamin___ Other Supplements _____

How many days a week do you consume: Caffeine_____ Alcohol_____ Soft Drinks _____ How much?_____

About how much water do you drink daily? _____

Activity

Do you follow a regular exercise program? ❑No ❑Yes ***How many days a week?*** _____

Are your leisure activities: ❑ Sedentary ❑ Active ❑ Good balance of rest and activity

Stress

Do you smoke? ❑No ❑Yes ***What is your stress level?*** ❑High ❑Medium ❑Low

Do you experience problems sleeping? ❑No ❑Yes Type of problems: _____

Sun

Have you used a tanning bed in the last 48 hours? ❑No ❑Yes

How frequently are you exposed to the sun or use a tanning bed? ❑Infrequently ❑Frequently ❑Regularly

How many sunburns have you had before age 21? _____ After age 21? _____

Does your job require you to work outdoors or drive often? ❑No ❑Yes

Do you wear contact lenses? ❑No ❑Yes ***Do you wear glasses?*** ❑No ❑Yes

Associated Skin Care Professionals

C.A.T. skin assessment system

Skin Care History: Medical

Do you use any topical products prescribed by a medical professional? ❑No ❑Yes

Products: _____

Do you use any products prescribed by a medical professional for acne or rosacea? ❑No ❑Yes

Products: _____

Any recent surgery, including plastic surgery? ❑No ❑Yes Details: _____

Any injectable cosmetic procedures (e.g. Botox, Restylane)? ❑No ❑Yes Details: _____

Do you form thick or raised scars (keloid scars) from cuts, burns or other physical trauma? ❑No ❑Yes

Do you get discoloration or redness in your skin after healing from physical trauma? ❑No ❑Yes

Skin Care History: Cosmetics & Treatments Used

Have you ever had an adverse reaction to any skin care product, waxing, lash extension, body or facial treatment?

❑No ❑Yes

Please check all that apply, and name the product or treatment that caused it.

❑Rash ❑Irritation ❑Peeling ❑Sun Sensitivity ❑Breakout ❑Other _____

What skin care products are you currently using? (Specify what skin type they are designed for, if known.)

	AM: Cleanser/Toner	
	Moisturizer/SPF/Eye Cream	
	Makeup	
	Other	
	PM: Cleanser/Toner	
	Serum/Eye Cream/Night Cream	
	Other	
	WEEKLY: Prescriptions/Scrubs/Masks	
	PROFESSIONAL: Face/body treatments, waxing, peels etc that you visit a professional to receive regularly	

Have you used any of the following hair removal methods in the past 2 weeks? Please check all that apply.

❑Shaving/Dermaplaning ❑Waxing/Sugaring ❑Electrolysis

❑Tweezing ❑Threading ❑Depilatories (Cream)

Future Appointments/Contact

May I contact you by phone to confirm future appointments? ❑No ❑Yes Text Message? ❑No ❑Yes

May I contact you by email about future promotions and news? ❑No ❑Yes

May I give you professional home care recommendations and a treatment plan to address your needs? ❑No ❑Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. ***I understand withholding information or providing misinformation may result in adverse skin reactions from treatments or products received.*** *I am aware that it is my responsibility to inform the skin care professional of my current medical or health conditions, and to update this history when necessary. I release this institution and/or skin care professional from liability and assume full responsibility thereof.*

Client Name: _____ Date: _____

Client Signature: _____

Esthetician: _____

Associated Skin Care Professionals