

Facial intake:

Name: _____

Date: _____

Are you pregnant? YES NO

Please list any medications you are taking: _____

Do you have any allergies: _____

Have you or have you ever used Accutane Retinol Hydroquinone

When? _____

Do you tan or use tanning beds regularly? _____

Do you have any of the following?

Acne	YES	NO		
Blood Pressure	HIGH	LOW	NORMAL	
Cancer	YES	NO		
Claustrophobic	YES	NO		
Diabetes	YES	NO		
Eczema	YES	NO	Where	_____
Epilepsy	YES	NO		
Headaches	YES	NO	How often	_____
Hepatitis	YES	NO		
HIV/AIDS	YES	NO		
Infections	YES	NO		
Lupus	YES	NO		
Menopausal	YES	NO		
Metal Implants	YES	NO	Where	_____
Pace Maker	YES	NO		
Phlebitis	YES	NO		
Varicose Veins	YES	NO		
Do you smoke?	YES	NO	How often?	_____
Do you wear contact lenses?	YES	NO		

I understand and am willing to comply with all pre and post care instructions. This procedure has been explained to me and my questions regarding the treatment, its complications and risks have been answered. I understand the procedure and accept the risks, and request that this procedure be performed on me.

Client signature: _____ Date: _____