KORIN KORMAN | Body+Beauty Lab

REGISTRATION AND MEDICAL HISTORY

I understand that treatment given at Body+Beauty Lab is for the purpose of general skin care and cosmetic improvements.

I understand that the Medical Injector and Medical Aesthetician does not diagnose or treat illnesses, diseases or any other physical or mental disorders including malignancy (cancer) or non-cosmetic skin abnormalities. As such, the treatment provider does not prescribe medical treatment or pharmaceuticals. It has been made very clear to me that this treatment is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I may have.

Because a Medical Injector and Medical Aesthetician must be aware of existing physical conditions, it is my responsibility to inform Body+Beauty Lab of all medical conditions and take it upon myself to keep my records updated on my physical health.

Date ______________________ Family Physician ____

Last Name ________________________________First Name ____________________________ Middle Initial:_______

Home Address: ____

City ____ State _______________________ Zip_________________

Email: ____Cell Phone: _____________________________________

DOB: _______________________ Age: ___________ Height: _______ Weight: _________

Are you currently under the care of a physician? Yes______ No______ Dermatologist? Yes______ No______

If yes, for what: ____

Do you have ANY Allergies? Yes______ No______

If yes, list all:____

Any allergies to Botox®, Dermal Fillers, Hyaluronic Acid Injections, Food, Latex, Aspirin, Local Anesthetics including Lidocaine, Hydrocortisone, Hydroquinone or skin bleaching agents? Yes______ No______

Type? ____

Do you have any active infection? Yes______ No______

If yes, list all:____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes______ No______

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes______ No______

If yes, list all:____

Medication currently taking including OTC, Birth Control Pills, Hormones, mood altering or anti-depression medication: ____

Previous Surgeries: ___________________________ Year_________

___________________________ Year_________

Please list all topical medications including Retin-A:

____

Have you ever used Accutane (Isotretinoin)? Yes_____ No_____ Last time used? ________________________

Do you take aspirin or blood thinners? Yes_____ No_____ How often? ______________________________

Do you take diet medication/herbal supplements? Yes_____ No_____ How often? ______________________

Have you ever had any facial surgery performed? Yes_____ No_____ Type? __________________________

Have you had facial laser resurfacing or deep chemical peeling in the past 3 months? Yes_____ No_____

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes_____ No_____

Have you recently used and self-tanning lotions or treatments? Yes_____ No_____

Have you ever laser hair removal? Yes_____ No_____

Have you had electrolysis, waxing, stringing or tweezing in the last 6 weeks? Yes_____ No_____

Have you ever had any of the cosmetic injectable procedures done? Yes_____ No_____ Type? ____________

Do you smoke? Yes____ No____ Drink alcohol? Yes____ No____ Do you exercise regularly? Yes____ No____

Fitzpatrick Skin Type: (circle one)

I Always Burns, Never Tans
II Always Burns, Sometimes Tans
III Sometimes Burns, Always Tans
IV Rarely Burns, Always Tans
V Brown, Moderately Pigmented Skin
VI Black Skin

For our female clients:
Are you pregnant or trying to become pregnant? Yes____ No____ Are you breastfeeding? Yes____ No____

Please check if you have had any of the following:

Alcohol Abuse		Diabetes		Migraines	
Anesthesia Problems		Disease Stimulated by Light/Heat		Multiple Sclerosis	
Angina		Drug Abuse		Pacemaker/Defibrillator	
Arthritis/Joint Problems		Eye Problems		Pregnancy/Nursing	
Asthma/Lung Disease		GI Problems/Ulcers		Seizure Disorder	
Autoimmune Disease		HIV/AIDS		Skin Cancer (current or history)	
Blackouts		Heart Attack/Stroke		Skin Disorders (keloids/vitiligo)	
Bleeding Disorders/Abnormalities		Hepatitis (list type)		Skin Infections (active)	
Breast Cancer		Hormone Imbalance		Tuberculosis	
Blood Transfusion Recipient		Hypertension (High Blood Pressure)		Tobacco Use	
Cancer		Kidney Disease		Thyroid Imbalance	
Cardiac Disorders		Liver Problems		Vascular Disease	
Cold Sores/Herpes		Metal Implants		Other:	

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

Client Signature____

Treatment Provider Signature____