YES ELECTROLYSIS

Client History Record

DATE:

NAME _____
First *MI* *Last*

ADDRESS _____

City _____ *State* _____ *Zip* _____

CELL # _____ Ok To Leave VM? Y N

EMAIL _____ Ok To Send Mail? Y N

OCCUPATION _____ **DOB** _____

REFERRED BY: _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? Y N

IF SO, PHYSICIAN'S NAME _____

MEDICAL HISTORY

Acne	Y	N	Hemophilia	Y	N
Whiteheads	Y	N	Folliculitis	Y	N
Blackheads	Y	N	Epilepsy	Y	N
Allergies	Y	N	Hepatitis (A/B/C)	Y	N
Canker Sores	Y	N	Herpes Simplex	Y	N
Carcinoma	Y	N	HIV	Y	N
Fever Blisters	Y	N	Keloid Scars	Y	N
Cold Sores	Y	N	Moles	Y	N
Psoriasis	Y	N	Warts	Y	N
Dermatitis	Y	N	Skin Tags	Y	N
Diabetes	Y	N	Vitiligo	Y	N
Genital Herpes	Y	N	Facial Scars	Y	N
Blood Moles	Y	N	Skin Tumors	Y	N
Spider Veins	Y	N	Hyper-Pigmentation	Y	N
Thyroid Disorder	Y	N			
Vitiligo	Y	N	Hypo-Pigmentation	Y	N
Eczema	Y	N			
			Congen. Adrenal Hyperplasia	Y	N

IMPLANTS

Pacemaker	Y	N	Cochlear Implant	Y	N
Metal Parts/Pins	Y	N	Hearing Aids	Y	N
Dental Implants	Y	N	Contact Lenses	Y	N

Other: _____

MENSTRUAL HISTORY

Hormonal Imbalance	Y	N	Hysterectomy	Y	N
Irregular Periods	Y	N	I.U.D.	Y	N
Menarche Menopause	Y	N			
Post Menopause	Y	N	Currently Pregnant	Y	N
	Y	N			

POLY CYSTIC OVARIES (PCOS) Y N
If Yes, First Diagnosed? _____
If Yes, Still Under a Dr.'s Care for This Condition? Y N

CUSHING SYNDROME Y N
If Yes, First Diagnosed? _____
If Yes, Still Under a Dr.'s Care for This Condition? Y N

OTHER FAMILY MEMBERS WITH EXCESSIVE HAIR? Y N
If Yes, Who? _____

ALLERGIES

Cool Breeze Antiseptic	Y	N	Cosmetics	Y	N
Sea Breeze Antiseptic	Y	N	Fragrances	Y	N
70% Alcohol	Y	N	OTC Topicals	Y	N
Aloe Vera	Y	N	Anesthetic Creams 4-5% (caines: benzo/lido/mar/tetra/pro/topi)	Y	N
Pain Killers	Y	N			

Other: _____

CURRENT MEDICATIONS

			DOSE	LENGTH
Oral Contraceptive	Y	N		
Cortisone	Y	N		
Hormones	Y	N		
High Blood Pressure	Y	N		
Anti-Coagulants	Y	N		
Dilantin (Seizure Drug)	Y	N		
Anti-Inflammatories	Y	N		
Depression/Mood Alter	Y	N		

Other: _____

CURRENT SKIN TREATMENTS

			HOW LONG AGO?
Accutane	Y	N	
Glycolic Topical/Peel	Y	N	
Retin-A (by RX)	Y	N	
Botox Injections	Y	N	
Collagen Injections	Y	N	
Dermal Fillers	Y	N	
Chemical Peels	Y	N	
Microdermabrasion	Y	N	
Light/Laser Treatments	Y	N	

(Skin Rejuvination / Photorejuvination/ Acne Blue Light / Laser Resurfacing / LP Skin Treatments / Micro-Needling)

Other: _____

DO YOU HAVE AN UNUSUAL SKIN CONDITION? Y N
Explain: _____

PREVIOUS ELECTROLOGY TREATMENTS? Y N
None / Flash / Thermolysis / Blend / Galvanic / Unknown

FORMER TEMP METHODS OF HAIR REMOVAL? Y N
Laser / Shaving / Tweezing / Waxing / Sugaring / Threading
Trimmer / Scissors / Other: _____

PREVIOUS LASER HAIR REMOVAL OR ELECTROLYSIS

ELECTROLYSIS 1st Trtmnt _____ Last Trtmnt _____
Areas Treated: _____

LASER 1st Trtmnt _____ Last Trtmnt _____
Areas Treated: _____

DESCRIBE ANY MANIFESTATIONS OF PRIOR TREATENTS:

_____

_____

DESIRED TREATMENT AREAS (CIRCLE ALL THAT APPLY)
Hairline / Brows / Nose / SideFace / Ears / Upper Lip / Chin
Nape / Neck / Breasts / Chest / Back / Arms / Under Arms
Hands / Fingers / Abdomen / Bikini Line / Thighs / Legs
Feet / Toes / Other: _____

WHAT AREAS MOST CONCERN YOU? _____

I acknowledge that all information contributed by me is accurate to the best of my knowledge. The present condition of areas to be treated is as stated on this record. I have read and understand the "After-Care Treatment Instructions" card given to me today. I understand that a series of treatments are necessary for permanent results. If I am unable to keep my appointment, I will provide my Electrologist at least 24 hours notice. If I do not, I understand I will be granted one grace offense. I understand second or more offenses will occur in a 100% charge for the time I reserved.

Client Signature _____ Date _____

DATE:

Client History Record

CLIENT # ____________

CLIENT NAME: ______________________________

CELL PHONE: ______________________________

DATE	AREA	MODE	mA'S	VOLTS	SEC'S	PROBE	FEE	MINUTES	COMMENTS