rejūv
MEDICAL AESTHETIC CLINIC

SKIN / HEALTH ASSESSMENT

Name: _____ **Date:** _____

❑ Y ❑ N Do you have any allergies? Please list allergy and your reaction: _____

❑ Y ❑ N Do you have any medical conditions? Please List: _____

❑ Y ❑ N Are you taking any medications, vitamins and/or supplements? Please List: _____

❑ Y ❑ N Have you had any surgeries? Please List: _____

❑ Y ❑ N Have you ever had any type of cancer?
If yes, please explain when diagnosed and what kind: _____

❑ Y ❑ N Are you currently being treated for cancer?
If yes, please explain the type of treatment you are receiving: _____

❑ Y ❑ N Do you have, or have you had, unusual skin lesions?
If yes, please explain: _____

❑ Y ❑ N When you have a cut, scratch or sore does your skin color have a tendency to hyper or hypo pigment?

❑ Y ❑ N Do you have a history of Keloid scarring? (white, raised, hardened scars)

❑ Y ❑ N Do you have a history of skin disorders such as: eczema, psoriasis, rashes?

❑ Y ❑ N Do you bruise easily or heal slowly?

❑ Y ❑ N Are you a smoker?

❑ Y ❑ N Do you have a pacemaker?

❑ Y ❑ N Are you under the care of a dermatologist or physician? Please explain: _____

❑ Y ❑ N Are you pregnant? ❑ Y ❑ N Attempting pregnancy? ❑ Y ❑ N Breastfeeding?

❑ Y ❑ N Do you have a history of cold sores?

❑ Y ❑ N Have you used ACCUTANE in the past 6 months?

❑ Y ❑ N Do you use tanning beds? How often? _____ ❑ Y ❑ N Do you use sunscreen?

Your signature: _____ **Date:** _____

Clinic Staff Complete:
Date: _____

The non-client condition specific protocol is authorized:
__ **Authorized, <u>NO</u> exceptions**
__ **Authorized, <u>WITH</u> exceptions:** _____

RN:_____ **Medical Director:** _____