**Lori Murtagh, LE / Healthy Skin By Lori, LLC–Confidential Health History & Wax Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instagram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your job require outdoor work?  No  Yes,

1) What are your skin care concerns and challenges: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) What skin care products are you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Do you use a Clarisonic or similar at-home skin tool?  No  Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Have you been under the care of a physician, dermatologist or other medical professional within the past year?

 No  Yes, Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) Any recent surgery, including plastic surgery?  No  Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Any skin cancer?  No  Yes, Location & Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If any Mohs Surgery, Location and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7) Any other type of cancer?  No  Yes, Location/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8) Any removal of lymph nodes?  No  Yes, Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9) Do you smoke?  No  Yes 10) Do you exercise regularly?  No  Yes

11) Do you follow a restricted diet?  No  Yes, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12) On a scale of 1 to 5, what is your stress level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13) Do you have any **allergies** **to anything**, including prescription and over-the-counter medications, iodine, shellfish, seasonal allergies, cosmetics, skincare products, animals: Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14) Have you ever had an allergic reaction to Aspirin?  No  Yes

15) List any prescribed medications you take regularly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc). you take regularly:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17)  Do you use any type of topical Vitamin A (such as Retin-A/retinol), AHA, Benzyl Peroxide, Glycolic, Salicylic?

 No  Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Within last 3 months? \_\_\_\_\_\_\_

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18)  Do you currently use or have you used in the past Accutane or similar form?

 No  Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19) Do you have a pacemaker, internal defibrillator, metal implants or body piercings?  No  Yes Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20) Do you sunbathe or use tanning beds?  No  Yes In the last 48 hours?  No  Yes

21) List your daily consumption of: Water \_\_\_\_\_\_\_\_\_\_\_\_\_ Caffeine (Coffee/Soda/Tea etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22) Have you experienced claustrophobia  No  Yes

23) Have you had any of these in the last month:  Botox  Injectable  Chemical Peel  Microdermabrasion  laser or light therapy  other cosmetic procedure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24) Do you receive Dermaplaning services?  No  Yes Have you waxed within 72 hours:  No  Yes

25) Do you burn easily in moderate sunlight?  No  Yes 26) Do you have a tendency to redness?  No  Yes

27) Do you suffer from sinus problems?  No  Yes

28) Do you ever experience burning, itching, or stinging sensations on your skin?  No  Yes

Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29) Do you wear contact lenses?  No  Yes

30)  Do you form thick or raised scars from cuts or burns?  No  Yes

31)  Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?  No  Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

32) Have you had any of these health conditions in the past or present? (Please check all that apply and provide additional information in the space provided)

 Frequent Cold Sores  Fever blisters  
 Hormone imbalance  Headaches (Chronic)   
 Systemic disease  Hepatitis  
 High blood pressure  Herpes  Diabetes  Hysterectomy

 Lupus  Spinal injury  
 Immune Disorders  Phlebitis, blood clots, poor circulation  
 Thyroid condition/Hashimoto’s  HIV/AIDS  
 Heart problem  Blood clotting abnormalities  
 Arthritis  Insomnia/Sleeping problems  
 Asthma  Keloid Scarring  
 Eczema  Skin Disease/Lesions  
 Psoriasis  Any active infection  
 Seizure disorder or Epilepsy  Varicose veins

**Male Clients:**

33. Do you have any shaving concerns, irritation from shaving or ingrown hairs?  No  Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Clients:**

34) Are you taking oral contraception?  No  Yes

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35) Are you pregnant or trying to get pregnant?  No  Yes 36) Are you lactating? No Yes

37) Are you currently having or due for your menstrual period?  No  Yes

38) Any menopause problems?  No  Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

39) I consent to newsletters being emailed to me as I can easily unsubscribe at any time? (They are typically monthly unless a time sensitive notice is being sent.)  No  Yes

**Notice and Consent**

I understand that because esthetics includes maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time. I voluntarily agree to assume those risks and I release and hold harmless the practitioner and business from any claims related thereto. I give my consent to receive treatment from this practitioner.

I understand that the services offered are not a substitute for medical care. Any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information provided is to aid the esthetician in giving better service and is completely confidential.

**WAXING SERVICES:**

**Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc.**

I have read the above information and if I have any concerns, I will address these with my esthetician. I give permission to my esthetician to perform the waxing procedure we have discussed and will hold her and the business harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product / post-treatment care, I will consult the provider immediately.

I understand, have read, and completed this questionnaire truthfully and I have had sufficient opportunity to have questions answered. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions. I understand the service and risks and agree to update this history in the future. The treatments I receive here are voluntary and I release this business and/or skin care professional from liability and assume full responsibility thereof.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treatment of Minor:**

I confirm that I have read and understand all information on the applicable forms for this treatment/service and accept responsibility on this child’s behalf for any disclosures or liability described on those forms. I agree to supervise any home care procedures that are recommended as a result of the treatment.

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

03/30/22