**Zoee Beauty Bar - Client Confidential Health History Form (p.1)**

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, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, skin care 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, Salicyclic?

 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) 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covid-19:**

COVID-19 is a highly contagious virus that spreads from person to person. In addition to long-held and explicit sanitation measures this business has always adhered to, new preventative measures have been put in place to further reduce the spread of this novel coronavirus. However, those best practices still offer no guarantee regarding your potential risk of being infected.

39. Have you tested positive with COVID?  No  Yes, specify date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

40. Have you had a fever within the last 24 hours of 99.9 F or above?  No  Yes

41. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat or shortness of breath?

 No  Yes

42. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?  No  Yes

**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.**

**I understand, have read, and completed this questionnaire truthfully. 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 and to update this history. The treatments I receive here are voluntary and I release this institution 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Esthetician Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ESTHETICIAN NOTES**:

|  |  |
| --- | --- |
| DATE: |  |
| DATE: |  |
| DATE: |  |