CONFIDENTIAL CASE HISTORY

NAME ____________________

ADDRESS ____________________

CITY ____________ STATE ________ ZIP ______

PHONE: HOME ________ WORK ________ EXT. ______

AGE ____ BIRTH DATE ________ REFERENCE ________

PHYSICIAN ____________ PHONE ________

ARE YOU UNDER DOCTORS CARE? ____________

MEDICATION ____________________

ILLNESS OR DEFECT ____________________

MEDICAL HISTORY: HAVE YOU HAD?		EXPLANATION.
AIDS - ARC	NO ☐ YES ☐	
ALLERGIES	NO ☐ YES ☐	
BIRTH CONTROL PILLS	NO ☐ YES ☐	
BRUISE EASY	NO ☐ YES ☐	
CONTACTS LENS	NO ☐ YES ☐	
DIABETES	NO ☐ YES ☐	
HEART CONDITION	NO ☐ YES ☐	
HEMOPHILIAC	NO ☐ YES ☐	
HEPATITIS	NO ☐ YES ☐	
HERPES SIMPLEX	NO ☐ YES ☐	
HIGH BLOOD PRESSURE	NO ☐ YES ☐	
HYSTERECTOMY	NO ☐ YES ☐	
KELOID SCARS	NO ☐ YES ☐	
METAL IN BODY	NO ☐ YES ☐	
PACEMAKER	NO ☐ YES ☐	
PREGNANT	NO ☐ YES ☐	
REGULAR PERIODS/MENOPAUSE	NO ☐ YES ☐	

DATE ____________

PREVIOUS TREATMENTS: NONE ☐ THERMOLYSIS ☐ GALVANIC ☐

	HOW LONG	AREA
RAZOR		
TWEEZERS		
DEPILATORY		
WAX		
OTHER		

CONDITION OF GROWTH ____________________

CONDITION OF SKIN ____________________

I acknowledge that all information contributed by me is accurate to the best of my knowledge, and that the present condition of the areas to be treated is as stated on this record. I understand that repeated treatments are necessary.

SIGNATURE ____________________ DATE ________

TYPE OF HAIR:

SHALLOW (S) NORMAL (N) DEEP (D) DISTORTED (X)

UPPER LIP ______ CHIN ______ EYEBROWS ______ ARM ______

LEG ______ UNDERARM ______ OTHER ______

SKIN REACTION ____________________

PATIENT REACTION ____________________

AFTER CARE MEDICATION ____________________

SENSITIVITY ____________________

COMMENTS ____________________