Health Questionnaire

Occupations

Profession: ______ Sports activities/hobbies: ______

Do you expose yourself to the sun? Yes ◯ No ◯ Outside act. ◯ Tanning bed ◯ Self-tanning spray ◯

Self-tanner ◯

General Hygiene Habits

How often do you visit beauty salons? ______

Do you have specific concerns regarding your skin? ______

Which beauty products do you use at home? From which brand? ______

◯ Cleanser: ______	◯ Night cream: ______	◯ Body (milk/gel/bath): ______
◯ Day cream: ______	◯ Lips/eyes: ______	◯ Exfoliant: ______
◯ Lotion: ______	◯ Shaving: ______	◯ Mask: ______
◯ Makeup: ______	◯ Aftershave: ______	◯ Other: ______

Epilation-Specific:

Have you ever undergone electrolysis treatments? Yes ◯ No ◯

On which part of the body? ______ For how long? ______ Date of last session: ______

Have you ever undergone laser/IPL treatments? Yes ◯ No ◯

On which part of the body? ______ For how long? ______ Date of last session: ______

Have you had a sudden pilosity outbreak on the treated region(s)? Yes ◯ No ◯

For how long: ______ Where? ______ Reason? ______

Temporary Methods Used :

◯ Wax	◯ Decoloration	◯ Sugar	◯ Sanding
◯ Shaving	◯ Sissors	◯ Depilatory cream	◯ Tweezers
◯ Electric Epilator	◯ Threading	◯ Home light-based epilator	

Frequency: ______ Last epilation: ______

I, the undersigned, declare that I have answered the questions above to the best of my knowledge and that I release from liability the salon, its manager and all its personnel from any damage of incident that may occur during treatment. It is my sole resposibility to inform the technician or practitioner of any change in my situation.

Client's signature: ______ Date: ______

Dates	Changes		Initials	Dates	Changes		Initials	Dates	Changes		Initials
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	
	Yes ◯	No ◯			Yes ◯	No ◯			Yes ◯	No ◯	

Each client must write down their initials in the provided space at each visit in order to confirm that the information provided previously is still valid.

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Health Questionnaire

File # : _____

General information

Surname : _____ Name : _____

Gender: ◯ Male ◯ Female Date of Birth : _____

Address : _____ City : _____ Postal Code : _____

Phone (res./cell) : _____ (work) : _____ Referred by: _____

Are you being subjected to a medical follow-up? Yes ◯ No ◯

Name of doctor: _____ Medical provider : _____

Do you suffer from allergies/intolerances? _____ Sun-related? Yes ◯ No ◯

Past or upcoming surgical interventions : _____ General anaesthesia : Yes ◯ No ◯

Are you pregnant? Yes ◯ No ◯ Last pregancy: _____ Menopause : Yes ◯ No ◯

Do you follow a particular dietary regimen?: Yes ◯ No ◯ Do you believe you have a well-balanced diet?: Yes ◯ No ◯

Do you take medication? Yes ◯ No ◯ If so, specify : _____

- ◯ Hormones
- ◯ Contraceptive pill
- ◯ Contraceptive implant
- ◯ Cortisone
- ◯ Anti-inflammatory
- ◯ Antibiotics
- ◯ Antidepressant
- ◯ Anticoagulant
- ◯ Anti-histamine
- ◯ Aspirin
- ◯ Accutane
- ◯ Gold salts
- ◯ Steroids
- ◯ Naturopathy
- ◯ Homeopathy
- ◯ Sedatives
- ◯ Diuretics

Do you use/eat/drink:

- ◯ Alcohol
- ◯ Coffee/Tea
- ◯ Tobacco
- ◯ Drugs
- ◯ Protein supplements
- ◯ Spicy food
- ◯ Chocolate
- ◯ Fast Food
- ◯ Water (8 glasses/day)

Other: _____

Do you have:

- ◯ Tattoos
- ◯ Scars
- ◯ Piercings
- ◯ Keloids
- ◯ Scabies
- ◯ Eczema
- ◯ Psoriasis
- ◯ Hives
- ◯ Vitiligo
- ◯ Saline implants
- ◯ Contact lenses
- ◯ Retinal prosthesis
- ◯ Cochlear implant
- ◯ Dental implant
- ◯ Pacemaker
- ◯ Metal inclusion
- ◯ IUD
- ◯ Regular menstrual cycle

Do you suffer or did you suffer from:

- ◯ Skin diseases
- ◯ Prolonged bleeding
- ◯ Haemophilia
- ◯ Anemia
- ◯ Heart conditions
- ◯ Arterial disorders
- ◯ High cholesterol
- ◯ Arteriosclerosis
- ◯ Circulatory problems
- ◯ Phlebitis (Thrombophlebitis)
- ◯ Varicose veins
- ◯ Varicositis
- ◯ Scoliosis
- ◯ Osteoporosis
- ◯ Arthrosis
- ◯ Arthritis
- ◯ Water retention
- ◯ Raynaud's disease
- ◯ Infectious disease
- ◯ Immune disorder
- ◯ Tuberculosis
- ◯ Respiratory problems
- ◯ Asthma
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Chronic exhaustion
- ◯ Mononucleosis
- ◯ Burnout
- ◯ Claustrophobia
- ◯ Ovarian disorders
- ◯ Polycystic ovary syndrome
- ◯ Adrenal gland problems
- ◯ Thyroid disorders
- ◯ Constipation
- ◯ Intestinal problems
- ◯ Kidney disease
- ◯ Herpes
- ◯ Hepatitis A/B/C
- ◯ AIDS
- ◯ HIV
- ◯ Cancer/remission
- ◯ Skin cancer
- ◯ Diabetes (type 1 and 2)
- ◯ Hypoglycemia
- ◯ Nervous disorders
- ◯ Epilepsia
- ◯ Ankylosis
- ◯ Fibromyalgia
- ◯ Loss of sensitivity
- ◯ Paralysis
- ◯ Musculoskeletal issues

Other : _____

Did you ever undergo:

- ◯ Chemical peeling
- ◯ Mechanical dermabrasion
- ◯ AHA / BHA / PHA
- ◯ Botox or dermal fillers
- ◯ Vitamin A (retinoid acid)
- ◯ Hydroquinone
- ◯ Laser resurfacing
- ◯ Rejuvenation techniques
- ◯ Thermocoagulation

Please provide any additional information that you deem appropriate regarding your health and/or medical history :

_____

_____

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