LASTING IMAGE FACE & BODY

HEALTH HISTORY ASSESSMENT for WAXING

LAST NAME (Please Print) _____ FIRST NAME _____ DATE OF VISIT_____

ADDRESS _____ CITY_____ ST_____ ZIP _____

HOME PH _____ CELL PH _____ CARRIER _____

EMAIL: _____ BIRTHDATE _____ /_____ / _____

REFERRED BY ❑ INTERNET ❑ YELP ❑ PHONE BOOK ❑ PHYSICIAN ❑ FAMILY ❑ OTHER: _____

WHAT AREAS ARE YOU INTERESTED IN TODAY? _____ FUTURE? _____

CONDITIONS: *Have you ever experienced any of the following? (check all that apply)*

❑ Diabetes ❑ Warts ❑ Dermal Abrasions ❑ Stomach Ulcers ❑ Poor Circulation
❑ HIV ❑ Moles ❑ Varicose Veins ❑ MRSA ❑ High Blood Pressure
❑ Hepatitis ❑ Easy Bruising ❑ Sensitivity to Oils

MEDICATIONS: *Are you currently using any of the following? (check if currently using)*

❑ Accutane ❑ Tetracycline ❑ Cortisone ❑ Thyroid Medication ❑ Retin-A (Last 6 months)
❑ Other Steroids ❑ Blood Thinning Medication ❑ Glycolic/AHA/Salicylic/Lactic/BPO-Benzoyl Peroxide

Are you currently under the care of a dermatologist? ❑ yes ❑ no If yes, why?_____

Please indicate the date of our most recent:

Tanning (Sun) _____ Chemical Peel/Laser_____

Tanning (Bed) _____ Waxing _____

GENERAL HEALTH: Current Medication _____ Date of Last Physical _____

❑ Acne ❑ Allergy to Metal ❑ Hepatitis ❑ Healing Problems ❑ Cold Sores ❑ Herpes
❑ TB ❑ Warts ❑ Cancer ❑ Diabetes ❑ HIV ❑ Keloids
❑ High Blood Pressure ❑ Pacemaker ❑ Pigment Problems ❑ Currently Pregnant

THIS FORM WILL COVER ANY TIME YOU HAVE HAIR REMOVAL TREATMENTS FROM LASTING IMAGE FACE AND BODY.
We recommend not exposing your skin to the sun or indoor tanning for at least 48 hours after the waxing service.

ACKNOWLEDGMENT AND CONSENT

_____ _____ If I incur any problems with services and/or products, I will contact Lasting Image and communicate my concerns to her immediately.
initial date

_____ _____ I acknowledge all information given by me is accurate to the best of my knowledge and agree to notify Lasting Image Face & Body whenever there are changes. I understand that a series of treatments are necessary to achieve desired reduction in hair and agree to follow all aftercare instructions.
initial date

_____ _____
signature date