HALE&HUSH® GENERAL CONSENT

CONTACT INFORMATION Date:

Last Name: First Name: M.I.: Date of Birth: Age:

Cell: Work/Home: Email:

Address: City: State: Zip:

Emergency Contact: Relationship: Emergency Phone:

How were you referred to us?

SKIN TYPE

Which of the following best describes your skin type? (please check one)

❑ Creamy complexion	Always burns, never tans	❑ Matte complexion	Rarely burns, always tans
❑ Light complexion	Always burns, sometimes tans	❑ Brown complexion	Rarely burns, deep tan
❑ Light/Matte complexion	Sometimes burns, always tans	❑ Black complexion	Never burns, deeply pigmented

MEDICAL HISTORY

Are you currently under the care of a Physician? ❑ YES ❑ NO

If yes, for what?

Are you currently under the care of a Dermatologist? ❑ YES ❑ NO

If yes, for what?

Do you have any of the following medical conditions? (please check all that apply)

❑ Cancer	❑ Thyroid Imbalance	❑ Keloid Scarring	❑ High Blood Pressure
❑ Herpes	❑ Rosacea	❑ Hepatitis	❑ Frequent Cold Sores
❑ HIV / AIDS	❑ Diabetes	❑ Blood Clotting Abnormalities	❑ Skin Disease / Skin Lesions
❑ Seizure Disorder	❑ Arthritis	❑ Skin Cancer	❑ Hormone Imbalance
❑ Any Active Infection			

Have you had any surgery where lymph nodes were removed? ❑ YES ❑ NO

Do you have any other health problems or medical conditions? Please list:

For our female clients:

Are you pregnant or trying to become pregnant? ❑ YES ❑ NO

Are you breastfeeding? ❑ YES ❑ NO

Are you using oral contraception? ❑ YES ❑ NO

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ALLERGIES

Have you had an allergic reaction to any of the following?: (please check all that apply & describe the reaction)

❏ Food ❏ Latex ❏ Aspirin ❏ Lidocaine ❏ Hydrocortisone ❏ Hydroquinone or skin bleaching agents

Have you ever had a skin reaction to a fragrance? ❏ YES ❏ NO Or dislike any fragrances? ❏ YES ❏ NO

Please list any fragrances with issues:

MEDICATIONS

Please list all medications you are currently taking:

Topical medications:

Herbal Supplements:

Have you ever used Accutane? ❏ YES ❏ NO If yes, when did you last use it:

HISTORY

Have you used any of the following for hair removal in the last six weeks?

❏ Shaving ❏ Waxing ❏ Electrolysis ❏ Plucking/Tweezing ❏ Threading ❏ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ❏ YES ❏ NO

Have you recently used any self-tanning lotions or similar treatments? ❏ YES ❏ NO

Do you form thick raised scars from cuts or burns? ❏ YES ❏ NO

Have you ever had Hyper-pigmentation (darkening of the skin) or Hypo-pigmentation (lightening of the skin) or marks after physical trauma? ❏ YES ❏ NO

If yes, please describe:

LIFESTYLE

What type of climate do you live in?

Occupation

Hobbies/Activities

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the Esthetician, Technician, Therapist, Doctor or Nurse of my current medical and health history and to update any current conditions. A current medical history is essential for the caregiver to execute the appropriate treatment procedures. (All information is strictly confidential)

Signature Date