General Information:

Name _____
Last *First* *(MI)*

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Date of Birth _____

Is your family aware that you are receiving treatments?
❑ Yes ❑ No

How were you referred?
❑ Person ❑ Yellow Pages ❑ Other _____

Are you under a physician's care? ❑ Yes ❑ No

Physician's Name _____

Medical History:

Condition	Yes	No	Comments
Acne	❑	❑	
Allergies	❑	❑	
Canker Sores	❑	❑	
Carcinoma	❑	❑	
Cold Sores	❑	❑	
Contact Lenses	❑	❑	
Dermatitis	❑	❑	
Diabetes	❑	❑	
Genital Herpes	❑	❑	
Heart Condition	❑	❑	
Hemophilia	❑	❑	
Hepatitis	❑	❑	
Herpes Simplex	❑	❑	
H.I.V. Tested	❑	❑	
Keloid Scars	❑	❑	
Metal Pins in Body	❑	❑	
Moles	❑	❑	
Pace Maker	❑	❑	
Females Only:			
Hormonal Imbalance	❑	❑	
Hysterectomy	❑	❑	
Irregular Periods	❑	❑	
I.U.D.	❑	❑	
Menopause (Current)	❑	❑	
Post Menopause	❑	❑	
Pregnant	❑	❑	

Additional explanation of medical history:

_____

_____

_____

_____

Do you have any female blood relatives with excessive hair?
If yes, who: _____

_____

Allergies/Sensitivities	Yes	No	Comments
Alcohol	❑	❑	
Aloe Vera	❑	❑	
Anesthetics	❑	❑	
Cosmetics	❑	❑	
Latex Gloves/Powder	❑	❑	
Local - Topical	❑	❑	
Sea Breeze	❑	❑	
Other: _____	❑	❑	
Prescription Treatments *(Benzocaine, Lidocaine, Marcaine or Zylocaine)*	❑	❑	

Current Medications	Yes	No	Type & Dosage
Birth Control Pills	❑	❑	
Cortisone	❑	❑	
Hormones	❑	❑	
Other: _____	❑	❑	

Current Skin Treatment	Yes	No	Application
Accutane	❑	❑	
Glycolic Topical/Peel	❑	❑	
Retin-A	❑	❑	
Renova	❑	❑	
Other: _____	❑	❑	

Do you have any unusual skin condition? ❑ Yes ❑ No
Explain: _____

Previous Electrology Treatments:
❑ None ❑ Blend ❑ Galvanic ❑ Thermolysis ❑ Unknown

Former Methods of Hair Removal:
❑ Depilatory ❑ Shaving ❑ Tweezing ❑ Waxing ❑ Other

Have you had Laser hair removal? ❑ Yes ❑ No
If yes, when, where and how many treatments: _____

_____

Describe any manifestation of prior treatments on skin:

_____

_____

Desired treatment areas:

❑ Chin	❑ Back	❑ Abdomen
❑ Ears	❑ Breasts	❑ Arms/Underarms
❑ Eyebrows	❑ Chest	❑ Bikini Line
❑ Nose	❑ Hairline	❑ Feet/Toes
❑ Sides of Face	❑ Hands/Fingers	❑ Legs
❑ Upper Lip	❑ Nape/Neck	❑ Thighs
❑ Other: _____	❑ Other: _____	❑ Other: _____

I acknowledge that all information contributed by me is accurate to the best of my knowledge, and that the present condition of areas to be treated is as stated on this record. I understand that repeated treatments are necessary for permanent results. If I am unable to keep my appointment, I will give my electrologist at least 24 hours notice. If I do not, I will be charged for the time I reserved.

_____ _____
Signature *Date*