ReYouStudio
TATTOO REMOVAL & MEDI SPA

# CLIENT INFORMATION & MEDICAL HISTORY

*In order to provide you with the safest and most appropriate laser treatment, we need for you to answer all parts of the following questionnaire honestly and completely, and let us know if anything changes. This information, especially your medical/health history and status, may critically affect the procedure we may recommend or safely undertake. All information will be held in the strictest confidence.*

## PERSONAL HISTORY

Today's Date_____

Last Name _____First Name_____

Date of Birth _____Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____Work Phone _____Cell Phone_____

OK to send a text message reminder? Yes _____ No _____ Email Address_____

What is your preferred contact method? Home _____ Work _____ Cell _____ Text _____ Email _____

Emergency Contact Name _____Phone _____

Reason for your visit: _____

Have you ever had laser treatments before?_____If yes, when was last treatment?_____

What area was treated?_____

How did you hear about Re.You Studio? _____

Referred by _____Other _____

## ASSIGNMENT

I understand that I am financially responsible for all charges. I understand that Re.You Studio does not accept insurance and that insurance carriers do not typically cover these services.

Signature_____Date_____

## MEDICAL HISTORY

Have you ever had any of the following medical conditions? Please circle all that apply.

Cancer
Arthritis
Hepatitis
Skin disease/skin lesions
Any Active infections
Diabetes
Frequent cold sores
Seizure Disorders
Blood clotting abnormally
High blood pressure
HIV/AIDS
Thyroid imbalance
Herpes
Keloid Scarring
Hormone Imbalance
Intestinal Ulcers/ bleeding

Do you or your family history of atypical moles, vitiligo, developing keloids, melanoma, or skin cancer?

Yes_____ No_____

Have you ever had any surgeries? Please list:_____

_____

Do you have a history of skin rash produced by exposure to intense heat or infrared irritation?_____

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

_____

Are you currently under the care of a **physician**? Yes_____ No_____

Physician name_____

If yes, for what? _____

Are you currently under the care of a **dermatogist**? Yes_____ No_____

Physician name_____

If yes, for what? _____

**(Females) Are you pregnant or trying to become pregnant? Yes_____No_____**

**SKIN TYPE**

Which of the following best describes your skin type? (Please circle one)

| | | | |
|---|---|---|---|
| I. | Always burns, never tans | IV. | Rarely burns, always tans |
| II. | Always burns, sometimes tans | V. | Brown, moderately pigmented skin |
| III. | Sometimes burns, always tans | VI. | Black skin |

Do you regularly use tanning salons or sunbathe? Yes_____ No_____

If yes, how often? _____Last time? _____

Do you have any discoloration in the area to be treated from tanning/sun/other? Yes___ No____

Do you form thick or raised scars from cuts or burns? Yes___ No____

Has there been any scarring in the area to be treated? Yes___ No____
If yes please describe: _____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) after physical trauma? Yes___ No____

Have you ever had Gold Therapy for arthritis? Yes___ No____

**MEDICATIONS**

Please list all medications you are currently taking, including antibiotics, birth control pills, hormones, topical medications and creams, vitamins, herbs, supplements, etc.

_____

_____

_____

Are you on any mood altering or anti-depression medication? _____
Have you ever used Accutane, and if so when did you last use it? _____

**ALLERGIES**

Have you ever had an allergic reaction? Check all that apply and describe reaction.

_____ Food _____ Latex _____Aspirin _____Lidocaine _____ Hydrocortisone

_____ Hydroquinone or Skin bleaching agents _____ Antibiotics _____ Other Medications

_____ Other Please describe reaction: _____

**SOCIAL HISTORY**

Do you smoke? Yes_____ Used to smoke, but quit_____ Never_____

If yes, how much do you smoke?_____How long have you smoked? _____

How much alcohol do you consume per week?_____

How much caffeine do you consume per week?_____

**PATIENT CONSENT**

I certify that the medical, personal and skin history statements I have provided to Re.You Studio are true and correct. I am aware that it is my responsibility to inform Re.You Studio of my current medical/health status and conditions and to update this information. I understand that a current medical history is essential for Re.You Studio physicians and staff to execute appropriate treatment procedures.

**Signature** _____ **Date** _____

**Assessed by** _____ **Date** _____