Metamorphos Skin Care

Further enhance your innermost beauty and outermost expression

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name____ Today's Date_________________________________

Date of Birth____________Age____________Occupation____

Home Address________________________________City_________________________ Zip Code_________________

Home Phone _________________________Work_________________Cell____________________________________

E-Mail Address____

Emergency Contact Name and Phone____

HEALTH HISTORY

Please check all that apply:

Heart Disease ___

Mental Health disorder ___

Bleeding problem ___

Keloid Scars ___

Skin Cancer ___

Diabetes ___

Liver Disease ___

Rosacea ___

Neurological disorder ___

Bells Palsey ___

Cold Sores/Shingles ___

Auto-immune disorders ___

Other ____ Explain:____

Allergic reaction ____

Please list all medications including prescription and over the counter drugs (aspirin, anti-inflammatories), vitamins, herbs, supplements, birth control pills.

____

Have you had any previous laser treatment or other skin treatment? Y N

Describe: ____

Are there any moles with hair in the area to be treated? Y N

Females: Are you pregnant? Y N Are you breastfeeding? Y N

Do you smoke? Y N If yes, how much and for how long? ____

Do you have a pacemaker, implanted defibrillator or other cardiac device? __________________________

I confirm that the answers to the questionnaire are true and correct. I also confirm that the provider has clarified any questions I did not understand.

Signature of Client: ____ Date: ________________