

SKIN DEEP ESTHETICS HAIR REMOVAL PROFILE

Name: _____ Phone No. _____

Address: _____ Work No. _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: ***under** 18 _____ 18-25 _____ 26-32 _____
33-40 _____ 41-50 _____ 51-60 _____ 61 & over _____

Occupation: _____ Email: _____

Referred By: _____

Medical History:

Are you using Retin A or any Retinol products? Yes ___ No ___

Are you currently using Glycolic? Yes ___ No ___

Are you taking Accutane? Yes ___ No ___ If yes, how long? _____

Are you under a doctor's care now? Yes ___ No ___ Please explain: _____

Doctor's Name: _____ Phone No. _____

Have you had hair removal in the past? Yes ___ No ___ If yes, how long ago? _____

Have you had laser hair removal? Yes ___ No ___ If yes, how long ago? _____

Are you allergic to anything? Yes ___ No ___ Please list allergens: _____

Are you currently taking any medications/vitamins? Please list: _____

Do you have a cold sore breakout at this time? Yes ___ No ___

(Please note that your hair removal service will be rescheduled if a cold sore is visible)

Do you experience skin reactions to hair removal? Yes ___ No ___

Please explain: _____

Please note that hair removal by tweezing or waxing may cause redness, slight swelling or bumps for some people. Please avoid the sunlight for the next 24 hours and wear sunscreen since just waxed skin is extremely sensitive to sunburns. Do not use any harsh scrubs or chemicals on the face for the next 48 hours as this can irritate the skin further. I certify that the above information is true and accurate, to the best of my ability.

Signature: _____ Date: _____

*(If under the age of 18 years old, a parent or guardians signature is required)