HEALTH HISTORY ASSESSMENT

Name _____
Address _____
E-mail _____
Today's Date _____ Home Phone _____
Referred by _____ Work Phone _____
Date of Birth/Age _____ Emergency or Cell Phone _____
Instructions for Calling _____

CIRCLE AREAS TO BE TREATED:

Front Hairline	Brows	**Upper/Lower Lip**
Cheeks/Sideburns	**Chin/Under Chin**	Throat/Jawline
Ears	Nape of Neck	Back
Chest/Breasts	Shoulders/Upper Arms	Forearms
Underarms	Hands/Fingers	**Upper/Lower Abdomen**
Upper/Inner Thighs	Lower Legs	Feet/Toes

Other Areas _____

HORMONE-RELATED QUESTIONS for females with hair growth on areas above in **bold.**

What age did hair growth begin?_____ Regular menstrual cycle every _____ days.

Circle all that apply:

Fertility problems	Hormone/Endocrine disorder	Scalp hair loss
Weight gain/loss	Family history of similar hair growth	Irregular menses
Acne	Hysterectomy or Menopause	Eating disorder

Other hormone problems or explanation of above: _____
What do you believe caused your hair growth? _____
Electrologist's notes: _____
_____
_____

PREVIOUS METHODS OF HAIR REMOVAL

Circle all methods that you have used and add date when last used:

Shaving _____	Waxing/Sugaring/Threading _____	Bleaching _____
Cutting/Clipping _____	Tweezer/Patch/Swab _____	Laser _____
Depilatories _____	Tweezing _____	Light-Based _____
No methods used _____	Other methods (explain) _____	
Electrolysis _____	Name of previous electrologist: _____	

How long did you use these methods of hair removal? _____weeks _____months _____years

How often do you remove your hair? DAILY WEEKLY MONTHLY INFREQUENTLY

Skin reactions to previous hair removal methods: circle all that apply

Redness	Pimples	Infections	Pigmentation
Ingrown hair	Swelling	No skin reaction	

Other _____ _____

Permission to photograph area to be treated: YES NO *(please initial)* _____

Electrologist notes: _____
_____