



Hillsborough Electrolysis Center Health History Form

Privacy requested Y or N
Photographs to show progress Y or N

Name _____ Date _____
Phone (Home) _____ (Work) _____ (Cell) _____ Emergency _____
Address: _____ City _____ State _____ Zip _____
Email Address: _____ Birth Date/Age _____ Sex _____
Instructions for Calling/leaving a message _____
Referred by _____ Phone: _____

ELECTROLYSIS

Circle Areas you wish to have treated

Facial/Head Areas

*Upper Lip *Neck Eyebrows Ears
*Lower Lip *Sideburns Nasal Bridge Hairline
*Chin *Cheeks Nose Other

Body Areas

*Sternum *Back Bikini Line Chest
*Breasts *Spine Thighs Shoulders
*Abdomen *Buttocks Legs Underarms
*Arms Other

If hair growth is present in females in above areas noted with asterisk(*), explain if onset was sudden or gradual, and over what period of time _____

Family History (female blood relatives) with similar growth patterns _____

Previous Electrology _____ Modality Used: Thermolysis _____ Blend _____

Was previous treatment successful _____ Reason for discontinuing treatment _____

Temporary Methods Used _____

MEDICAL INFORMATION

Family Physician _____ Phone _____ Gynecologist _____ Phone _____

Dermatologist _____ Phone _____ Other Physician _____ Phone _____

Exam by Gynecologist or Endocrinologist _____ Last exam _____

Describe any pre-existing skin conditions (Scarring, Acne, Pigmentation, Rash, Telangiectasia (spider veins), Growths) _____

Recent skin infections/problems _____ Explain _____

Problems with skin healing _____ Explain _____

Ever use Retin A _____ Dates _____ Explain _____

Diseases/conditions

Hemophiliac Circulatory Problems Diabetes Asthma Bruise Easy
Herpes Simplex *Keloid Scars *Pacemaker Hepatitis Hepatitis Blood Test
HIV HIV Blood Test *Metal In Body *Pregnant High Blood Pressure
Epilepsy Heart Valve Problems Other

Comments on the above circles: _____

Allergies

Cosmetics Topical Anesthetics Latex
Medicines Stainless Steel Foods
Soaps Sun Other

Current Drugs

Hormones Birth Control Pills
Dilantin ACTH
Cortisone Minoxidil Other

Do you have any temp/perm implants i.e. IUD, Dental, Orthopedic _____ Do you wear contacts _____

Menstrual History: Regular _____ Irregular _____ Menopause _____

If post menopausal, give date of last menses _____ Was menstrual cycle regular _____ increase/decrease of hair _____

Hysterectomy _____ Date _____ Ovaries removed _____ increase/decrease of hair _____

Estrogen/progesterone therapy _____ Dates/explain _____ increase/decrease of hair _____

Ever take Birth Control Pill _____ Dates/explain _____ increase/decrease of hair _____

Ever had an ovarian cyst or cystic ovaries _____ Dates/explain _____ increase/decrease of hair _____

Is thyroid function normal _____ Explain _____

Changes in weight or voice _____ Explain _____

Ever had hormone level tested _____ Date/results _____

I understand health history information is important to the electrologist in order to provide me with safe and effective treatments. I acknowledge all information given by me is accurate to the best of my knowledge and ***I agree to update my health history assessment whenever there are changes.*** I understand a series of treatments is necessary to achieve permanent hair removal based on my previous temporary methods of hair removal, the science of electrolysis, and my individual physiological factors. ***I have been advised of the post-treatment healing process, the possible risks related to treatment and agree to follow all aftercare instructions and to notify the electrologist of any difficulty in healing.***

Client Signature

Date

Parent/Guardian signature of minor

Date

I acknowledge the following tissue alterations in areas to be treated _____

Client Signature

Date

Parent/Guardian signature of minor

Date

Additional Notes: