Electrology Client History

Personal Information

First Name	Last Name	Middle Initial
Date of Birth	Sex	Address
City/ State/ Zip Code	Phone	

CHECK ALL THAT APPLY	Hirsute	PCOS	Cushing's	Thyroid

Hysterectomy Pregnant Other

Current or past methods of hair removal

Past Medical History

Allergies	Cardiac	Surgery
O None O Unknown Medical Allergies: _____ _____ _____ _____ _____ _____ _____	O None O Unknown O Angina O Arrhythmia O Cardiomyopathy O High Blood Pressure O Congenital O Implanted Defib O MI Other_____	O None O Unknown O Abdominal O Heart O Lung O Other_____ _____ _____ _____

Chronic Illnesses

O None O Asthma O Bleeding Disorder O Cancer O COPD O CVA / TIA O Diabetic	O Dialysis/Renal O Gastrointestinal O Headaches O Hepatitis O HIV + O Hypertension O Paralysis	O Psychological O Seizures O Substance Abuse O TB O Unknown Other_____ _____

Current Medications

O None O Unknown _____

_____

Emergency Contact Information

Primary Physician	Physician Phone Number
Primary Contact Name & Relationship	Primary Contact Phone Numbers
Dermatologist / Phone	Endocrinologist / Phone

Permission to contact above Yes ☐ No ☐ Other Contact Directions

Current Methods of Hair Removal / Former Treatments

Signature _____ Electrologist _____

Date _____