Columbia Skin Clinic
Electrolysis - Health History Form

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
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 ______________________________
Ever use Accutane _____ Dates ______ Explain ______________________________

DISEASE/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	Vertigo	PCOS	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

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 pervious temporary methods of hair removal, the science of electrology, 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.***

Patient Signature Date Parent/Guardian signature of minor Date

I acknowledge the following tissue alterations in areas to be treated

Patient Signature Date Parent/Guardian signature of minor Date

Consent of Electrolysis Treatment:
I authorize, Ann Guerra – Certified Electrologist, of Columbia Skin Clinic to perform electrolysis on me. I acknowledge that the electrolysis process has been explained in detail. I have been fully informed and have discussed in detail the potential risks and side effects of electrolysis treatment and more specifically the risk of scarring due to:

1. The use of certain topical or oral medications such as Accutane, Retin-A, Retin-A like topicals, Tazorac, Ciana, Atralin, Epiduo, Differin and anti-aging acids, etc.
2. Excessive hair removal.
3. Failing to follow post treatment regimen.

I agree that I am voluntarily requesting electrolysis treatment and I agree to accept all the risks associated with receiving electrolysis treatment including any scarring or side effects that may result from treatment. I further agree to indemnify Ann Guerra and Columbia Skin Clinic for any scarring or other side effects that may occur as the result of receiving electrolysis treatment.

Patient Signature Date Parent/Guardian signature of minor Date

Additional Notes: