**Beauty Institute and Spa Inc.**
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# Medical History Form for DermaRoller/ eDermaStamp Treatments

Personal Information:

| | |
|---|---|
| Name: | Date of Birth: |
| Address: | Occupation: |
| Tel./Cell: | E-mail Address |

Health Questionnaire:

| | |
|---|---|
| Existing or recent illness: | Details: |
| Hospitalization / surgery: | Details/Date: |
| Medication: | Details: |
| Medicine intolerance: | Details: |
| Aesthetic procedures in the treatment area within the last 6 months: | Details/Date: |
| Allergies (including to cosmetic products) | Details: |

**Do any of the following conditions apply to you? (Please indicate if any)**

- ☐ Under 18 years of age.
- ☐ Pregnancy or nursing.
- ☐ Current or history of cancer, especially skin cancer, or pre-malignant moles.
- ☐ Any active condition in the treatment area such as sores, active pustular acne, rosacea, keloid or raised scars, septic conditions, psoriasis, eczema and rash as well as irritated or damaged skin due to excessive fresh tanning.
- ☐ Any active bacterial, viral or fungal infections
- ☐ Vascular disorders such as: un-controlled diabetes, nervous diseases, cardiac disorder and cancer. In such cases, consult the treating physician.
- ☐ Any recent use of products such as Accutane or Retin A.
- ☐ Taking blood pressure, blood thinning or heart medications.
- ☐ Actinic (solar) keratosis - Immunosuppression

I, the undersigned pledge to inform of all changes in my physical condition.

I confirm that I do not suffer from any of the above described conditions.

I declared that the above information is true and correct.

| Customer's Name: | Signature | Date |
|---|---|---|
| | | |
| Practitioner's Name: | Signature | Date |
| | | |