Patient Profile

Name:______________________________DOB:________________Age:________

Address:____

City:______________________State:_____Zip:__________

Preferred Contact Phone Number:____

Email Address:____

Emergency Contact (Name and number):_______________________________________

How did you hear about Ease Electrolysis, LLC?____

What type of work do you do?____

- Do you have a communicable disease that we should know about (Ex.: HIV, Hepatitis)?__________
- Are you pregnant or lactating? Yes___No___
- Last menstrual period?____
- Do you wear contact lenses? Yes___No___(Remove contacts if eyes are sensitive.)
- Do you currently use or receive depilatories or waxing? Yes___No___(Discontinue use five days pre- and post-treatment.)
- Are you in the habit of going to tanning booths? Yes___No___
  (If within past 14 days, decline treatment; we recommend this practice is discontinued altogether.)
- Are you applying any topical medications at this time? Yes___No___ Which one(s)?_____________
- (High percentages of certain ingredients may increase sensitivity)
- Are you currently using any topical Retinoid prescriptions
  (Trentinoin/Retin-A®/Renova® /Differin®/ Tazorac®/Avage®/ EpiDuo™/Ziana®)? Yes___No___
  What strength?______ For how long?________
  (Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Are you currently using "Accutane"? Yes___No___For how long?_________

Those who are currently taking Accutane® should be directed to their dispensing physician.

- Have you had a chemical peel or any type of procedure within the last 14 days? Yes___No___
- Do you have regular collagen, Botox® or other dermal filler injections? Yes ___No__
  (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)
- Have you recently had facial surgery? Yes___No___Describe:__________________________
- Have you recently had laser resurfacing? Yes ___No___ When?________ What type?__________
- Do you smoke or use tobacco? Yes ___No___
- Do you develop cold sores/fever blisters? Yes___No___
- Are you allergic/sensitive to? (Check all that apply)

  Milk ___ Apples ___ Citrus ___ Grapes___ Aloe vera___ Aspirin ___ Perfumes___ Latex___ Hydroquinone___ Mushrooms___

  If any other allergies, what?____
- Have you ever used any other products that caused a bad reaction? Yes___No___ Describe: _______________
- Are you taking any medication at this time? (Antibiotics may increase sensitivity)______________
- What is your hereditary background?____
- Skin tone:____
- Do you consider your skin: Sensitive___ Resilient___ Unsure___?
- Please Describe Your Skin:____

Client Acknowledgment and Agreement I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status. I hereby release and discharge Ease Electrolysis, LLC and its employees and agents from any and all claims that I have or may have in the future in connection with my treatment relating to any and all procedures performed by Ease Electrolysis, LLC, regardless of the results.

Patient Signature:_________________________________Date:________________