Bella Waxing Services

Date__________________

Last Name______________________________ First ____________________________

Address________________________________ Phone_____________ Cell___________

City__________________________________ State _____________ Zip ___________

1. Have you ever been seen by a dermatologist? Yes_____ No _____ if yes, for what reason? ____

2.Please list all medications that you take regularly, include hormones, vitamins etc.

____

3.Are you taking Accutane or any other acne medications? Yes_____ No_____

4.Do you use Retin A, Renova. Or other topical vitamin A? Yes _____No _____ if yes, for how long ____________________________________
5.Do you have any allergies? Are you allergic to any medications? Yes_____ No _____
Please list. ____
6. Are you Pregnant or Lactating? Yes _____ No _____
7. Have you ever had any of the following?
_____ Laser resurfacing
_____ Light Chemical Peel
_____ Medium/Heavy Chemical Peel
Do you ever experience tightness or flaking of your skin? Yes _____ No _____
Do you tan or frequent tanning booths? Yes _____ No _____
Do you have a history of fever blisters or cold sores? Yes _____ No _____

I__________________________________ am_____ am not______ presently using:

_______ Retin A or any other topical Vitamin A
_______ Accutane or any other acne medication
_______ Any exfoliant or hydroxy based products
_______ Any medications such as cortisone, blood thinners, or diabetic medication

I understand that if I begin using any of the above products and do not inform my esthetician prior to hair removal I am accepting full responsibility for any skin reactions. The hair removal process has been thoroughly explained to me and I have had opportunity to ask questions and receive satisfactory answers.

Client Signature Date

____ __________________