Client History Form

First and Last Name:_____
Pronouns (circle all that apply)**:** They/Them She/Her He/Him Other:_____
Gender (circle all that apply)**:** Female Male Non-Binary Transgender/Trans Other____
Sex Assigned at Birth: Female Male Intersex
Date of Birth: _____ **Age:**_____
Address:_____
City: _____ **State:**_____ **Zip:**_____
Cell:_____ **Ok to leave a message?** Yes No
Email:_____
How did you learn about Bare Babe Electrolysis?_____
Are you currently under the care of a physician? Yes No
Physician's Name:_____

Medical History: *Please check any of the following that you've experienced, even if not an active issue.*

- ☐ Acne
- ☐ Allergies
- ☐ Blackheads
- ☐ Blood Moles
- ☐ Cancer
- ☐ Canker Sores
- ☐ Congenital Adrenal Hyperplasia
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Facial Scars
- ☐ Folliculitis
- ☐ Hemophelia
- ☐ Hepatitis (A, B, C)
- ☐ H.I.V.
- ☐ Hyper-pigmentation
- ☐ Hypo-pigmentation
- ☐ HSV-1 (oral herpes)
- ☐ HSV-2 (genital herpes)
- ☐ Keloid Scars
- ☐ Moles
- ☐ Psoriasis
- ☐ Skin Tags
- ☐ Skin Tumors
- ☐ Spider Veins
- ☐ Thyroid Disorder
- ☐ Vitiligo
- ☐ Warts
- ☐ Whiteheads
- ☐ Other skin condition not listed (specify) _____

Medical Devices: *Please check any of the following that apply.*

- ☐ Contact Lenses
- ☐ Cochlear Implants
- ☐ Copper IUD
- ☐ Dental Implants
- ☐ Hearing Aides
- ☐ Metal Pins/Plates
- ☐ Pacemaker

Menstrual History: *Please check any of the following that apply. Skip if not applicable.*

- ☐ Hormonal Imbalance
- ☐ Hysterectomy
- ☐ IUD
- ☐ Irregular Periods
- ☐ Menopause (Current)
- ☐ Post-Menopause
- ☐ Pregnant
- ☐ Trying to Become Pregnant

Have you been diagnosed with PCOS? Yes No
If yes, when were you diagnosed? _____
If yes, are you still under a doctor's care for this condition? Yes No
If yes, are you taking any medications for this condition? Yes No

Gender Affirming Surgery (GAS) *Please circle any of the following that apply. Skip if not applicable.*
Currently undergoing Preparing to undergo Already completed
Surgery Date (if applicable):_____
Are you still under a doctor's care? Yes No

Have you been diagnosed with Cushing Syndrome? Yes No
If yes, when were you diagnosed? _____
If yes, are you still under a doctor's care for this condition? Yes No
If yes, are you taking any medications for this condition? Yes No

Have you been diagnosed with Diabetes? Yes No
If yes, when were you diagnosed? _____
If yes, are you still under a doctor's care for this condition? Yes No
If yes, are you taking any medications for this condition? Yes No
If yes, do you have any issues with circulation or wound healing? Yes No

Do you have a history of seizures? Yes No
If yes, when were you diagnosed? _____
If yes, are you still under a doctor's care for this condition? Yes No
If yes, are you taking any medications for this condition? Yes No

Do you have family members with excessive hair growth? Yes No
If yes, who? _____

Current Medications: *Please check any of the following that apply.*

- ☐ Accutane (last 6 months)
- ☐ Anticoagulants
- ☐ Antiseizure
- ☐ Benzoyl Peroxide Creams (last 2 weeks)
- ☐ Birth Control (specify) _____
- ☐ Insulin
- ☐ Retin-A/Retinol (within last 2 weeks)
- ☐ Steroids (specify) _____
- ☐ Hormone Replacement Therapy (HRT):
  - ☐ Estrogen
  - ☐ Progesterone
  - ☐ Anti-Androgen
  - ☐ GbRhAntagonists
  - ☐ Testosterone
  - ☐ Other _____

Allergies: *Please check any of the following that apply.*

- ☐ Aloe Vera
- ☐ Cool Mist Antiseptic
- ☐ Isopropyl Alcohol 70%
- ☐ Other:_____
- ☐ Latex Gloves/Powder
- ☐ Sea Breeze Antiseptic
- ☐ Witch Hazel Astringent

Current Skin Treatments: *Please check any of the following that apply.*

- ☐ Accutane
- ☐ Botox Injections
- ☐ Chemical Peel
- ☐ Collagen Injections
- ☐ Dermal Fillers
- ☐ Glycolic Topical/Peel
- ☐ Laser and/or Light Treatment
- ☐ Microdermabrasion
- ☐ Microneedling
- ☐ Retinol/Retin-A

Have you had previous electrolysis treatment? Yes No
Date of First Treatment: _____ Date of Last Treatment _____
Area(s) Treated: _____
If yes, which modality were you treated with?

- ☐ Galvanic
- ☐ Thermolysis
- ☐ Flash Thermolysis
- ☐ Blend
- ☐ Unknown

Other Hair Removal Treatments: *Please check any of the following that apply.*

- ☐ Bleaching
- ☐ Depilatory
- ☐ Laser
- ☐ Plucking
- ☐ Shaving
- ☐ Sugaring
- ☐ Threading
- ☐ Trimming
- ☐ Waxing

Date of Last Treatment _____

What areas are you seeking Electrolysis treatment for? *Please check all that apply.*

- ☐ Abdomen
- ☐ Armpits
- ☐ Arms
- ☐ Back
- ☐ Bikini Line
- ☐ Breasts
- ☐ Chin
- ☐ Chest
- ☐ Ears
- ☐ Eyebrows
- ☐ Feet/Toes
- ☐ Groin (GAS)
- ☐ Hairline
- ☐ Hands/Fingers
- ☐ Lower Legs
- ☐ Nape/Neck
- ☐ Nose
- ☐ Sides of Face
- ☐ Thighs
- ☐ Upper Legs
- ☐ Upper Lip

I acknowledge that all information contributed by me is accurate to the best of my knowledge. The present condition of the areas to be treated is as stated on this record.

Name (Print): _____

Signature: _____

Date: _____