WAXING SERVICES

NAME:_____ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____HOME & CELL _____

E-MAIL ADDRESS:_____DOB:_____

HOW DID YOU HEAR ABOUT US?_____

PLEASE ANSWER THE FOLLOWING QUESTIONS: PLEASE INDICATE BY MARKING AN "X" WHETHER YOU HAVE NOW OR HAVE EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS. PLEASE INDICATE BY MAKING AN "X" WHETHER YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS.

_____DIABETES	_____DERMAL ABRASIONS	_____WARTS
_____HIGH BLOOD PRESSURE	_____EXCESSIVE MOLES	_____HIV
_____POOR CIRCULATION	_____VARICOSE VEINS	_____CORTISONE
_____ACCUTANE	_____TETRACYCLINE	_____GLYCOLIC ACID MED.
_____HIGH BLOOD PRESSURE MED.	_____THYROID MEDICATION	_____RETIN A
_____ALPHA HYDROXY ACID	_____STOMACH ULCERS	_____HYDROQUINONE

PLEASE LIST ANY TOPICAL PRESCRIPTIONS YOU ARE USING:_____

PLEASE LIST ANY SKIN CONDITIONS OR MEDICINES:_____

TANNING (SUN)_____ TANNING (BED)_____ WAXING:_____

CHEMICAL PEEL:_____

PLEASE LET US KNOW IF THERE ARE ANY CHANGES TO THIS FORM.

DO NOT EXPOSE SKIN TO THE SUN/INDOOR TANNING FOR AT LLEAST 48 HOURS AFTER THE WAXING SERVICE. I UNDERSTAND THAT I AM ACCEPTING ANY REACTION FROM A WAXING SERVICE.

CLIENT SIGNATURE:_____DATE:_____