APHRODITE SALON & SPA

HEALTH HISTORY

Last Name: ____________________ First Name: _____________________ Date of Birth: M______D______Y_____
Home Phone: ___________________________ Cell Phone:_ ____
Email address: ____
How did you hear about us? ____

What do you hope to accomplish during your treatment? ____
Have you had surgery in the past 12 months? ____

Do you have any allergies? ☐ No ☐ Yes: ____

Please circle all that apply

Acne	High Blood Pressure	HIV/AIDS
Burns/Skin Grafts	Low Blood Pressure	Kaposi's Sarcoma
Vitiligo	Cold Sores	Keloid Scars
Seizures	Diabetes	Hepatitis
Shingles	Eczema	Heart Disease
Cancer	Lupus Erythematosus	Psoriasis
Tattoos	Epidermolysis Bullosa	Gold Therapy
TB	Herpes	Rosacea
Fungus	Skin Conditions	Asthma
Arthritis	Phlebitis/Varicose Veins	Ingrown Toenails

Have you used Accutane in the last 6 months? Yes No
Are you currently using glycolic acid or Retin A? Yes No
Have you had any permanent cosmetic tattooing to the area to be treated? Yes No
Have you had any previous laser treatment or other skin treatments Yes No
Describe: ____
Do you burn easily in moderate sunlight? Yes No
Do you use sunscreen on a regular basis? Yes No
Have you had microdermabrasion? Yes No

Please list all medications you are currently taking and the condition it treats:
____
Do you wear contact lenses? Yes No
Are you on any type of hormone therapy? Yes No
Are you pregnant or trying to become pregnant? Yes No
What skin care product line are you currently using? ____
Do you have any internal pins, wires, artificial joints or metal implants? Yes No

I authorize Aphrodite Salon & Spa to perform __________________________. I understand that there is a rare possibility of side effects or complications such as skin allergies. The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered. I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required.
My signature certifies that I have duly read and understood the content of this consent form and gave the accurate information as to my health condition.

Client Signature: ________________________________ Date: ___________________________________

APHRODITE SALON & SPA

COVID-19 Screening Questionnaire

At Aphrodite Salon & Spa, the health and safety of our clients and staff has always been our top priority. To ensure we are providing the safest environment possible to deliver health care, we kindly ask you to please complete this brief questionnaire prior to your appointment. We appreciate your help and understanding with this measure.

Client Name: ____

Screening Questions	Pre-Screen		In-Office	
Have you travelled outside of Canada in the past 14 days?	YES	NO	YES	NO
Have you tested positive to COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	YES	NO	YES	NO
Do you have any of the following symptoms: • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Decrease or loss of sense of taste or smell • Chills • Headaches • Unexplained fatigue/malaise/muscle aches • Nausea/vomiting, diarrhea, abdominal pain • Pink eye • Runny nose/ nasal congestion without other know cause	YES	NO	YES	NO
If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES	NO	YES	NO

Any 'YES' response must be discussed with the managing dentist immediately.

When you arrive in the office:

- Only clients are allowed to come
- Wear a mask
- Sanitize your hands
- Have your temperature taken