



Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin care needs.

Date / /

| Name <i>(please print clearly)</i> | | | Date of Birth | |
|------------------------------------|------|----------|----------------|---|
| First | Last | M.I. | / | / |
| Street Address | | | City | |
| | | | | |
| State | | Zip Code | E-mail | |
| | | | | |
| Home Phone | | | Business Phone | |
| () | | | () | |

Please check if presently using any of the following? *(please ✓ all that apply)*

- Accutane Glycolic Acid/Alpha Hydroxy Acid Topical Vitamin C
 Hydroquinone Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin

Which conditions do you want to improve *(please ✓ all that apply)*

- Hyperpigmentation (Brown Spots) Acne/Acne Scarring Sun Damage Enlarged Pores
 Fine Lines & Wrinkles Age Spots Surgical Facial Scars Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? Yes No

Female Clients

- Are you on hormone replacement therapy? Yes No
 Are you presently taking birth control pills? Yes No
 Are you pregnant or planning to be? Yes No

All Clients

- Do you use a sunscreen/sun block? Yes No
 Do you sunbathe or participate in outdoor activities? Yes No

- Do you have or have ever had acne? Yes No
 Are you using or have ever used any medications for acne? Yes No

Name of medication _____

Have you seen a Dermatologist in the past year? Yes No

If yes, list doctors name and reason for visit _____

Are you presently under a doctor's care? Yes No

What medications do you take on a regular basis?

Have you ever had Herpes (cold sores)? Yes No

Have you ever been treated with Zovirax or any medication for Herpes? Yes No



Do you have Epilepsy or Diabetes? Yes No

If yes, you will be treated only with a doctors release!

Are you presently under a physicians care for any reason? Yes No

Explain _____

Do you use Biore or snore strips? Yes No

Have you had any of the following? Yes No (please ✓ all that apply)

Cosmetic Surgery Botox Injections Skin Cancer Dermatitis Keloid Scarring

Laser Resurfacing Chemical Peels Hepatitis Other (Specify) _____

Are you allergic to aspirin? Yes No

Do you have any other allergies? Yes No

If yes, list: _____

Do you smoke? Yes No

Do you take nutritional supplements? Yes No

Are you on a diet? Yes No

Do you exercise? Yes No

Do you wear contact lenses? Yes No

Have you had skin treatments (facials) before? Yes No

Are you currently having facials? Yes No

Have you had electrolysis or waxing in the past week? Yes No

Do you have those services done? Yes No

Have you had permanent cosmetics? Yes No

If yes, where? _____

How is your general health? Excellent Good Fair Poor

What skin care products are you currently using? _____

What is it about your skin you would like to change? _____

Is there any other information I should know before beginning your treatment? _____

**Client
Signature** _____