

Skin Care History Questionnaire and Waiver

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

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ E-mail address: _____

What results are you seeking from this facial? _____

Have you had a professional facial before? (Either here or elsewhere?) Yes _____ No _____

If yes, what did you NOT like about your last facial, if anything? _____

When was your last professional facial treatment? _____

Do you receive facials on a regular basis? _____

What type of work do you do? _____

Please rate your stress level from 1-5 (5 being the highest): _____

Have you seen a dermatologist in the past year? Yes _____ No _____

If yes, list dermatologist's name, contact info and reason for visit:

Are you presently under a physician's care? Yes _____ No _____

If yes, list physician's name and reason for visit:

Are you currently taking any medications? Yes _____ No _____

If yes, please list

Please circle the following conditions you have or had experienced:

- | | | |
|---------------|-----------------|------------------|
| •hypertension | •cold sores | •anemia |
| •metal plate | •hernia | •lupus |
| •diabetes | •stroke | •irregular pulse |
| •fainting | •contact lenses | •claustrophobia |

- cancer
- thyroid disorders
- high cholesterol
- varicose veins
- seizures

- eating disorder
- heart attack
- epilepsy
- headaches
- asthma

- hepatitis
- high/low blood pressure
- autoimmune disorder

Skin Care History

Are you currently having skin treatments? Yes _____ No _____

If yes, what type of treatment(s):

Please check if you are presently using or have used in the past any of the following:

_____ Benzoyl Peroxide (BP)

_____ Glycolic Acid (AHA)

_____ Lactic Acid (AHA)

_____ Resorcinol

_____ Salicylic Acid (BHA)

Do you take nutritional supplements? Yes _____ No _____

Do you exercise? Yes _____ No _____

Do you have a tendency to scar? Yes _____ No _____

Allergies:

Have you ever had an allergic reaction to any of the following:

ASPIRIN OR SALICYLATES Yes _____ No _____

MILK Yes _____ No _____

APPLES Yes _____ No _____

CITRUS Yes _____ No _____

GRAPES Yes _____ No _____

NUTS Yes _____ No _____

INGREDIENTS IN SKIN CARE PRODUCTS Yes _____ No _____

FISH, MARINE OR IODINE ALLERGIES Yes _____ No _____

LATEX Yes _____ No _____

Please list any other known allergies:

Female clients only:

Are you on hormone replacement therapy? Yes _____ No _____

Are you presently taking birth control pills? Yes _____ No _____

Are you pregnant or nursing? Yes _____ No _____

Do you have or have you had any of the following in the last 14 days?

_____ Facial Cosmetic Surgery

_____ Botox Injections

_____ Collagen Injections
_____ Fillers
_____ Light Treatments
_____ Laser Resurfacing
_____ Microdermabrasion

Other: _____

HOME CARE

What Skin care products are you currently using at home? (Circle all that apply)

Cleanser	Moisturizer
Vitamin C	Specialty Products
Toner	SPF
Exfoliants/Scrubs	Mask
Retinol/Tretinol	Glycolics/Salicylics

PRESCRIPTION PRODUCTS:

_____ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)
_____ Adapalene (Differin®)
_____ Azelaic Acid (Azelex®, Finacea™)
_____ Tazarotene (Tazorac®)
_____ Isotretinoin (Accutane)
_____ Triluma™
_____ Metrogel

Any other topical antibiotics: _____

PLEASE CHECK IF YOU ARE PRESENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING:

_____ Skin Cancer	_____ Broken Capillaries
_____ Dermatitis	_____ Treatment Reactions
_____ Keloid Scarring	_____ Hypopigmentation
_____ Acne	_____ Hyperpigmentation
_____ Rosacea	

SUN PROTECTION:

Do you use a sunscreen? Yes _____ No _____

Signature: _____ Date: _____

