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

PRESCRIPTION PRODUCTS:
_____ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)
_____ Adepalene (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 ANYOF THE FOLLOWING:
_____ Skin Cancer
_____ Dermatitis
_____ Keloid Scarring
_____ Acne
_____ Rosacea
_____ Broken Capillaries
_____ Treatment Reactions
_____ Hypopigmentation
_____ Hyperpigmentation

SUN PROTECTION:

Do you use a sunscreen? Yes_____ No_____

Signature:_____ Date:_____