Skin Care History Questionaire 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 your Skin Care Specialist to accurately analyze and assess your skin care needs.

Name: ____ Date: ____________________

Address: ____

City: ______________________________________ State: ____________ Zip: _____________

Home Phone: ___________________________ Business Phone: __________________________

Cell Phone: ________________________________ Date of Birth: _________________________

E-mail address: ____

Health History

What type of work do you do? ____

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 ______________

____

What is your genetic background? ____

How is your general health? ______ Excellent ______ Good ______ Fair ______ Poor

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

Please circle the following conditions you have or had experienced:

- hypertension
- metal plate
- diabetes
- fainting
- cold sores
- hernia
- stroke
- contact lenses
- anemia
- lupus
- irregular pulse
- claustrophobia
- cancer
- thyroid disorders
- high cholesterol
- varicose veins
- seizures
- eating disorder
- heart attack
- epilepsy
- headaches
- asthma
- hepatitis
- tooth fillings
- high/low blood pressure
- autoimmune disorder

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________

INGREDIENTS IN SKIN CARE PRODUCTS Yes________ No________

FISH, MARINE OR IODINE ALLERGIES Yes________ No________

LATEX Yes________ No________

If checked yes to any of the above, please explain ____

____

____

Please list any other known allergies:

____

Have you ever had Herpes Simplex? Yes________ No_______

If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax® (Acyclivor) or Abreva?

Yes_______ No________

Are you being treated for Hepatitis? Yes________ No________

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________

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 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?

Cleanser ______________________________ Vitamin C ______________________________

Toner ______________________________ Exfoliants/Scrubs ______________________________

Moisturizer ______________________________ Specialty Products ______________________________

SPF ______________________________ Mask ______________________________

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 ANY OF THE FOLLOWING:

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

SUN PROTECTION:

Do you use a sunscreen? Yes________ No________
What level of protection? ________
Do you sunbathe or participate in outdoor activities? Yes________ No________
Do you tan in a tanning booth? Yes________ No________
Have you tanned in a tanning booth in the last 14 days? Yes________ No_________
Have you had any direct sun exposure in the last 10 days? Yes________ No_______

WHEN EXPOSED TO THE SUN DO YOU:

________ Always burn, never tan
________ Always burn, sometimes tan
________ Sometimes burn, sometimes tan
________ Always tan

Do you feel your skin is sensitive? Yes________ No________

WHAT SKIN CONDITIONS DO YOU WANT TO IMPROVE?

________ Acne and/or breakouts
________ Facial Scarring
________ Hyperpigmentation (freckles, age spots)
________ Hypopigmentation
________ Enlarged Pores
________ Fine Lines and Wrinkles

OTHER ____

Is there any other necessary information your Skin Care Specialists should know before beginning your treatment? Yes________ No________

If yes, please explain ____

____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s). I understand I need to sign this waiver prior to every treatment provided, with ANY changes pertaining to the above questionnaire.

Client Signature: __________________________________ **Date:** _________________________

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Client Signature: __________________________________ **Date:** _________________________

Client Signature: __________________________________ **Date:** _________________________

Client Signature: __________________________________ **Date:** _________________________

○ Please check if permission is granted to use pictures for marketing and training purposes. Your name will remain anonymous.

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CLIENT'S NAME: ____DATE: ____________________

CLIENT'S CURRENT SKIN CARE PRODUCTS: ____

____

TREATMENT PROVIDED____

AREA TREATED: _________________________ HOW MANY LAYERS / TIME LEFT ON SKIN: ______________

PRODUCT USED TO PREP SKIN: Peel Prep Enzyme Glycolic 30% NEUTRALIZED: Yes No

MASK: None Soothing Gel Mask Calming Seaweed Mask Restorative Mask Refining Mask

ADDITIONAL PRODUCTS USED:____

RESULTS: Redness Hot Spots Frosting Other

COMMENTS: ____

- -

CLIENT'S NAME: ____DATE: ____________________

CLIENT'S CURRENT SKIN CARE PRODUCTS: ____

____

TREATMENT PROVIDED____

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