CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PLEASE PRINT Today's Date _____

First Name _____Last Name _____ Date of Birth ____/____/_____

Street _____ Apt. # _____ City _____ State _____ Zip _____

Phone – Home ( ) _____ Work ( )_____ Mobile ( ) _____

Dermatologist/physician _____ Phone ( ) _____

Emergency Contact _____ Phone ( ) _____

Your occupation _____E-Mail _____

Referred by ☐ Friend ☐ Mailer ☐ Walk-by ☐ E-mail ☐Gift Certificate ☐ Other_____

Skin Care Professional Name:

_____

1. What is the reason for your visit today?_____

2. What special areas of concern do you have?_____

EXPECTATIONS and HISTORY

3. Which conditions would you like to improve?

☐Acne scarring	☐ Hyperpigmentation
☐Acne	☐ Broken capillaries
☐Age spots	☐ Stretch Marks
☐Enlarged Pores	☐ Surgical/facial scars
☐Fine lines & wrinkles	☐ Other _____

4.Have you ever had facial treatment in the past? ☐ Yes ☐ No

5.What was your experience?_____

6.How would you describe your skin?

☐ Normal ☐ Dry ☐ Oily ☐ Combination ☐Sensitive ☐ Sun Damage

7.How would you rate your skin? (Circle one)

I Always burns, never tans
II Always burns easily, tans slightly
III Burns moderately – tans gradually
IV Seldom burn – Always tans well
V Rarely burns – Deep tan
VI Never burns – Deeply pigmented

1. Do you ever experience □ Flakiness? □ Tightness?
□ Redness? □ Excessive oily shine during day?

2. What is your present skin regimen?
□ Soap & water only □ Cleanser □ Toner □ Masque
□ Moisturizer □ Exfoliation □ Sun Block every day
Other_____

3. Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin?
□ Yes □ No

If yes, what are they?_____

4. Do you blush easily? □ Yes □ No

If yes, what are the contributing factors?
□ Emotions □ Foods □ Temperature changes □ Other _____

5. Do you □ Sun bathe? □ Use a tanning bed? How often?_____

6. Have you ever had □ Peels? □ Microdermabrasion □ Facial surgery
□ Cosmetic Surgery □ Botox □ Collagen Injections □ Laser resurfacing
How recently?_____

7. Are you under treatment for any current skin condition? □ Yes □ No
If yes, what?_____

8. Does your skin heal □ Fast? □ Scars? □ Pigments?

9. Do you bruise easily? □ Yes □ No

10. Do you get sores/blisters (Herpes Zoster/Shingles)? □ Yes □ No

11. What medications/hormone replacement/vitamins do you presently take?
_____

12. Have you ever used □ Accutane® □ Retin-A® □ Renova®
□ Topical Antibiotics □ Differin □ Tazarac □ Hydroquinone □ Alpha Hydroxy Acids?
If yes, when and for how long? _____

13. Any personal or family history of skin cancer? □ Yes □ No
Provide detail _____

14. How would you describe your overall health?
□ Excellent □ Good □ Fair □ Poor

15. Have you had any of the following, past or present?

Acne	□ Yes	□ No	When _____
Allergies	□ Yes	□ No	
Arthritis or Bursitis	□ Yes	□ No	
Blood Pressure	□ High	□ Low	□ Normal
Breast Implant	□ Yes	□No	
Cancer	□ Yes	□ No	
Cataracts	□ Yes	□ No	
Cholesterol	□ High	□ Low	□ Normal

Claustrophobic	□ Yes	□ No	
Diabetes	□ Yes	□ No	
Diarrhea/constipation	□ Yes	□ No	
Eczema	□ Yes	□ No	Where _____
Epilepsy	□ Yes	□ No	
Hay Fever	□ Yes	□No	
Headaches	□ Yes	□ No	How often _____
Heart Disease/Conditions	□ Yes	□ No	What_____
Hepatitis	□ Yes	□ No	
HIV/AIDS	□ Yes	□ No	
Infections	□ Yes	□ No	
Lupus	□ Yes	□ No	
Menopausal	□ Yes	□ No	
Metal Implants	□ Yes	□ No	
Pace Maker	□ Yes	□ No	
Phlebitis	□ Yes	□ No	
Serious Injury	□ Yes	□ No	What _____
Sleep problems	□ Yes	□ No	
Thyroid	□ High	□ Low	□ Normal
Varicose Veins	□ Yes	□ No	
Do you smoke?	□ Yes	□ No	
Do you wear contact lenses?	□ Yes	□ No	

16. Have you ever had a reaction to □ Cosmetics □ Metals □ Medication □ Food
    □ Fragrance □ Airborne particles? □ Other Explain_____

17. **FOR WOMEN**: Oral contraceptives?	□ Yes	□ No
Are you pregnant or trying to get pregnant?	□ Yes	□ No
Are you taking hormone replacement?	□ Yes	□ No
Do you experience hormone imbalances?	□ Yes	□ No
18. **FOR MEN:** Do you shave with	□ Electric shaver?	□ Razor?
Do you experience skin breakouts?	□ Yes	□ No
Do you have ingrown hair?	□ Yes	□ No

LIFESTYLE & DIET

1.	Is your stress level	□ High	□ Medium	□ Low
2.	Do you normally sleep well?	□ Yes	□ No	
3.	Do you regularly exercise?	□ Yes	□ No	
4.	Do you have food intolerances?	□ Yes	□ No	What?_____
5.	Do you follow any special diet?	□ Yes	□ No	

6. How many glasses of water do you consume daily? _____
7. How many cups of caffeine-type beverage (coffee, tea, soft drinks) do you consume daily?
   □ 1-3 cups □ 4 or more
8. In our treatment program, it may be necessary to recommend alterations to or additions in your home care regimen; would that be OK with you? □ Yes □ No

Your practitioner will recommend the appropriate schedule for future facial treatments or physician referral in order to achieve your skin improvement goals.

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INFORMED CONSENT RELEASE

I _____, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the skin care professional will completely inform me of what to expect in the course of treatment and will recommend adjustments to my regimen if deemed necessary. I also am aware that individual results are dependent upon my age, skin condition, and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will inform my skin care professional immediately.

I release and hold harmless the skin care professional [insert your name], [insert business name], and the staff harmless from any liability for adverse reactions that may result from this treatment.

POLICIES

1. We require 48-hours notice for cancellations. Cancellation for Monday must be phoned in on the Friday before.
2. If you are not satisfied with your service or products, please contact your skin care professional within 24-hours after your appointment so that the situation may be corrected. It is our policy to provide you with the best professional service and products customized for your skin condition.

I have read and understood all of the foregoing information _____ Date _____
Client Signature

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