

CONFIDENTIAL SKIN HEALTH SURVEY

PLEASE PRINT

Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ ZipCode: _____
 Telephone: _____ Email Address: _____

Emergency Contact: _____ Tel: _____

Dermatologist Name & Phone Number, if any: _____

Physician Name & Phone Number: _____

Occupation: _____

How Did you hear about us?: Friend, Flyer, Road Side Sign, Building sign, Internet, Gift Certificate

1: Is this your first facial? Yes _____ No _____

2: What is the reason for your visit today? _____

3: What special areas of concern do you have: _____

4: Are you presently under a physician's care for any current skin condition or other problem? Yes _____ No _____

If yes, please explain: _____

5: Are you pregnant? Yes _____ No _____ If so, how far along? _____

6: Are you taking birth control or hormone replacement? Yes _____ No _____ If so, what type? _____

7: Do you wear contact lenses? Yes _____ No _____

8: Do you Smoke? Yes _____ No _____

9: Do you often experience Stress? Yes _____ No _____

10: Have you had skin cancer? Yes _____ No. If yes when and where _____

11: Are you now using (or used in the past): Azelex _____ Differin: _____ Renova: _____ Retin-A: _____ Tazara Glycolic acid (AHAs): _____

If so when and for how long? _____

12: Are you now using (or used in the past) Accutane? Yes _____ No. If so, when and how long? _____

13: Do you have Acne? Yes _____ No. If so, where is it present most? _____

14: Do you experience frequent blemishes? Yes _____ No _____ If so, how frequent and where? _____

15: Do you have any allergies to cosmetics, foods or drugs? Yes : _____ No _____ If so, please ,list: _____

Home Care Regimen:

Please specify brand and when you use item:

Cleanser: _____ Scrub: _____

Toner _____ Mask: _____

Moisturizer: _____ Cream: _____

Sunscreen: _____ Other: _____

Please circle if you are affected by, or have any of the following conditions:

- | | | |
|------------------|---------------------|---------------------------|
| Asthma | Hepatitis | Metal bone pins or plates |
| Cardiac problems | Herpes | Pacemaker |
| Eczema | High Blood Pressure | Psychological Problems |
| Epilepsy | Hysterectomy | Sinus Problems |
| Fever Blisters | Immune Disorders | Skin Disease |
| Headaches | Lupus | Urinary or Kidney Problem |
| Diabetes | Low Blood Pressure | Cancer |

16: Are you presently taking any medication or under treatment for conditions listed above? Yes, _____ No _____ If so , please list _____

Please Read & Sign:

I understand that the services offered are not substitute for medicare care, and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Client Signature _____ Date: _____

Aesthetician's Signature _____ Date: _____