CONFIDENTIAL Skin Health and Medical History

Client Name_____
Last First Middle Initial

Client address_____**Apt/Unit**_____

City_____ **State** _____**Zip**_____

E-mail address_____**@**_____

Would you like to receive the special offers and monthly Newsletters by email? _____ Yes _____No

Phone: home/cell (_____)_____ **work** (_____)_____

Birthday _____ **Age:** _____

Emergency Contact: _____ **Phone:** _____

Who may we thank for the referral? _____ **How did you hear about us?** _____

Your Health

Within the last year, have you been under a Dermatologist or Physicians care/surgeries? ___Y___N

If yes, please specify_____

List any medications, supplements, vitamins, diuretics, slimming tablets, etc. that you take regularly_____

_____

Do you smoke? ___Y___N **Do you wear contact lenses?** ___Y___N

Do you have metal implants, a pacemaker, or body piercings? ___Y ___N

Are you prone to cold sores? ___Y___N If so, are you taking Medication for it? ___Y___N

***** Please understand full disclosure of any communicable health condition (i.e., cold, flu, conjunctivitis) is necessary to keep you and others healthy. If any of these conditions are present, we will kindly ask you to reschedule your appointment.**

Your Skin

What are your skin care goals today? _____

Do you have any skin problems pertaining to your face or body? ___Y___N

If yes, please specify_____

What skin care products are you currently using? ___soaps ___cleansers ___toners ___moisturizers ___masques ___ exfoliating scrubs ___eye treatments

What product lines? _____

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? ___Y___N

If so, how long ago? _____

Do you use Accutane, Retin A, Renova, or any other prescription skin products? ___Y ___N

If so, how long ago: _____

Are you currently using any products that contain the following ingredients?

___glycolic acid ___lactic acid ___ exfoliating scrubs ___any hydroxyl acid product ___vitamin A derivatives

How much plain water do you consume daily?

_____

Do you burn easily in moderate sunlight? ___Y___N

Which of the following best describes your skin type? (Please circle one type number)

I Creamy complexion Always burns easily, never tans
II Light Complexion Always burns, tans slightly
III Light/Matte Complexion Burns moderately, tans gradually
IV Matte Complexion Seldom burns, always tans well
V Brown Complexion Rarely burns, deep tan
VI Black Complexion Never burns, deeply pigmented

Have you used any of the following hair removal methods in the past six weeks? __ No __ Yes, circle all that apply.

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Do you ever experience these conditions on your skin?

___flakiness ___tightness ___extreme dryness ___excessive oil

other_____

Have you ever experienced claustrophobia? ___Y___N

Have you ever had a reaction or have allergies to any of the following? (Please be specific if any apply to you)

___sunscreens ___cosmetics ___ medicine ___ iodine ___ pollen ___ food ___ hydroxyl acids ___animals ___ fragrance ___

other_____

What areas of concern do you have regarding your Skin: (Please check any that apply and explain)

Breakouts/acne __ Blackheads/whiteheads __ Excessive oil/shine__ Rosacea __ Broken capillaries __
Redness/ruddiness __ Sun spot/liver ___ spot/brown spot __ Uneven skin tone __ Sun damage __
Wrinkles/fine lines __ Dull/dry skin __ Flaky skin __ Dehydrated ___Other_____

Eyes: __dehydrated __ wrinkles __ puffiness __ dark circles __ Other: _____

Lips: __dehydrated __cracked/chapped lips __ Other: _____

Are committed to making necessary changes: ___Y___N

Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)
If yes, please explain: _____

Soap _____
Mask _____
Cleanser_____
Exfoliator _____
Shower Gels_____
Sunscreen_____
Night Moisturizer/Cream_____
Toner _____
Eye Product _____
Day Moisturizer _____
Scrubs _____
Body Lotions _____
SPF_____
Make-Up Products_____
Other: _____

What SPF do you use on your face? _____ How often/when? _____

What SPF do you use on your body? _____ How often/when? _____

Have you had any recent tanning bed or sun exposure that changed the color of your skin? __ No __Yes
Specify: _____

Have you experienced Botox, Restylane or Collagen injections? __ No __ Yes

Specify: _____

Female Clients only

Are you taking oral contraception? ___Y___N

Any recent changes to or from your contraceptive treatment? __ No __Yes

If so, what and when: _____

Are you pregnant or trying to become pregnant? ___Y___N

Are you lactating? __ No __Yes

Any menopause problems? __ No __ Yes
Specify: _____

Are you undergoing any hormone replacement therapy? __ No __ Yes

Specify: _____

Male Clients Only:

What is your current shaving system? Wet shave __ Electric __

Do you experience irritation from shaving? __ No __ Yes **Ingrown hairs?** __No __ Yes

Please use this space to complete answers where space was insufficient.

_____

_____

_____

Your Own Comments

Is there anything else about you you would like to share or we should be aware of, that we did not ask you on the form? ___Y___N

If yes, please specify: _____

_____

_____

Future Appointments/Contact:

May I call you at your home, work or cell phone number to confirm future appointments? __ No __ Yes

Please be advised, in the event that you are unable to make your scheduled appointment, Bella Angelic SkinCare has a **48 hour** cancelation policy. Failure to give proper notice may result in a 25% cancelation fee.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____