Skincare History Questionnaire and Waiver

Please answer the following questions so that your Skincare Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skincare 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	cold sores	anemia	cancer	seizures	headaches
metal plate	hernia	lupus	thyroid disorders	eating disorder	asthma
diabetes	stroke	irregular pulse	high cholesterol	heart attack	hepatitis
fainting	contact lenses	claustrophobia	varicose veins	epilepsy	tooth fillings
					high/low blood pressure

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 skincare products Yes_____ No_____
Fish, marine or iodine allergies Yes_____ No_____
Latex Yes_____ No_____
If checked yes to any of the above, please explain_____

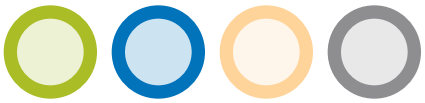
Please list any other known allergies:

_____

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_____

Skincare 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)
_____ Sulfur
_____ Vitamin A
_____ Vitamin C
_____ Hydrocortisone (HC)
_____ Hydroquinone (HQ)

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
_____ Chemical Exfoliation (Peels)
_____ Extractions
_____ Permanent Cosmetics
_____ Waxing
_____ Laser Hair Removal
_____ Hair Treatments (perm, color, etc.)

Other _____

Home Care:
What skincare products are you currently using at home?

Cleanser _____
Toner _____
Moisturizer _____
SPF _____
Vitamin C _____
Exfoliants/Scrubs _____
Specialty Products _____
Mask _____

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

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_____

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
_____ Rosacea
_____ Uneven Tone
_____ Uneven Texture
_____ Dehydration
_____ Oily
_____ Sun damaged

Other _____

Is there any other necessary information your skincare 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:_____

Client Signature: _____Date: _____

Client Signature: _____Date: _____

Client Signature: _____Date: _____

Client Signature: _____Date: _____

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.