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.
09: 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:_____