

**Skin Care Consultation**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Female \_\_\_\_\_ Male \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_ Best way to reach you? \_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_Friend \_\_Self \_\_Website \_\_Facebook \_\_Instagram \_\_Advertisement \_\_Other:\_\_\_\_\_\_\_\_\_

What is your primary goal for the service(s) you’ll be having today? (Improved complexion, preventative aging, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel about your skin’s condition now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin type (please circle): Dry Oily Normal Combo

Are you currently under a physician’s care for any current skin condition or other problems? \_\_Yes \_\_No

If so, What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a professional facial, chemical peel, laser or microdermabrasion? \_\_Yes \_\_No

If yes, What & Date of last service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**I Pale Complexion** -------------------------------- Always burns easily, never tans

**II Light/Fair Complexion** ----------------------- Always burns, tans slightly with difficulty

**III Light/Matte Complexion** ------------------- Burns moderately, tans gradually

**IV Matte Complexion/Light brown skin** --- Seldom burns, tans with ease

**V Brown Complexion** --------------------------- Rarely burns, tans very easily

**VI Black Complexion** ---------------------------- Never burns, deeply pigmented, tans very easily

Do you wear contact lenses? \_\_Yes \_\_No

Do you often experience Stress? \_\_Yes \_\_No

Are you currently using or ever used Accutane? \_\_Yes \_\_No \*If so, when and for how long? \_\_\_\_\_\_\_\_\_\_

Are you currently using Retin-A? \_\_Yes \_\_No \*If so, how many times a week & for how long? \_\_\_\_\_\_\_\_

Do you have acne? \_\_Yes \_\_No \*If so, how frequently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience blackheads, whiteheads, excessive redness, flaking/peeling? \_\_Yes \_\_No (Circle)

Have you used the following hair removal methods in the past six weeks? (Please Circle any that apply)

**Shaving Waxing Electrolysis Plucking/tweezing Stringing Depilatories Sugaring Threading**

Do you form thick or raised scars (keloids) from cuts or burns? \_\_Yes \_\_No

Do you experience hyperpigmentation (redness/brown spots) from burns, cuts, insect bites? \_\_Yes \_\_No

Are you pregnant or trying to become pregnant? \_\_Yes \_\_No

When were you last exposed to the sun, self- tanner or tanning booth? \_\_\_\_\_\_\_\_\_\_\_\_

Are you planning a vacation in the sun? \_\_Yes \_\_No How often do you sunbathe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain.)

**Cosmetics \_\_\_ AHA’s \_\_\_ Medicine \_\_\_ Animals \_\_\_ Plants \_\_\_**

**Fragrance \_\_\_ Food \_\_\_ Shellfish \_\_\_ Latex \_\_\_ Iodine \_\_\_**

 **Sunscreens \_\_\_ Pollen \_\_\_ Anesthesia \_\_\_**

 **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Explaination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have or have history of any of the following? **(Circle all that apply)**

**Active Infection**

**Arthritis**

**Asthma**

**Bleeding Disorder**

**Blush Easily**

**Bruising**

**Chemotherapy**

**Claustrophobia**

**Contact Lenses**

**Dark Spots**

**Diabetes**

**Eczema**

**Epilepsy/Seizures**

**Fever Blisters**

**Headaches**

**Heart Cond/Disease**

**Hepatitis**

**Herpes**

**High Blood Pressure**

**Hormone Imbalance**

**HIV/AIDS**

**Hysterectomy**

**Immune Disorders**

**Large Moles/Warts**

**Latex Allergy**

**Lupus**

**Metal Prosthetic Pins/Plates**

**MRSA/Staph Infect.**

**Pacemaker/Defib.**

**Psoriasis**

**Radiation Therapy**

**Rosacea**

**Skin Cancer/Mole**

**Skin Diseases**

**Skin Injury**

**Thyroid Conditions**

**Telangiectasia**

**Tobacco Use**

**Urinary or Kidney Problems**

**Vision Deficits**

**Other: \_\_\_\_\_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_**

Please indicate any medications that you are currently taking (including vitamins, topical and oral):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Water Consumption: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caffeine Consumption: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Describe your exercise habits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate what skin care products you use:**

Cleanser:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Toner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Moisturizer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exfoliate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sunscreen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mask: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescription: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Foundation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Powder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blush: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced Botox, Dysport, Xeomin, or injectable fillers? \_\_Yes \_\_No

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had facial resurfacing or facial plastic surgery in the past 3 months? \_\_Yes \_\_No

Are you planning on having facial resurfacing or facial plastic surgery? \_\_Yes \_\_No If so, when? \_\_\_\_\_\_

Are you planning on having eyelid surgery soon? \_\_Yes \_\_No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Future Appointments/Contact:***

May we call you at your home, work, or cell phone number to confirm appointments? \_\_Yes \_\_No

Best Phone number to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact you via email about future educational news and promotions? \_\_Yes \_\_No

I understand, have read and completed this questionnaire truthfully and to the best of my knowledge. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I understand it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_