

Name _____ DOB _____
 Address _____ Email _____
 Telephone _____ OK to email? Y N
 Emergency Contact _____ Telephone _____

Your Skin Goals and Concerns _____

- Your Skin Type
- Normal/Combo
 - Oily
 - Sensitive
 - Dry
 - Mild Acne
 - Moderate Acne
 - Mature / Aging

What skin products are you currently using? _____

What makeup products are you currently using? _____

Does your job and lifestyle require that you work/play outdoors? _____

Do you wax your facial skin on a regular basis? Y N

If yes, when was the last time? _____

Have you ever had facials, chemical peels, microdermabrasion or any resurfacing treatments? Y N

Are you using Retin-A? Y N Are you using Benzoyl Peroxide? Y N

Do you have any allergies or sensitivities? _____

- Do you have any of the below health issues?
- Cancer
 - Circulatory issues
 - Arthritis
 - Hormonal imbalances
 - Diabetes
 - Lactating
 - Psoriasis
 - Cold Sores
 - Chemotherapy
 - High blood pressure
 - Hysterectomy
 - Thyroid
 - Pregnant
 - Planning to be pregnant
 - Recent surgeries
 - Eczema

- Do you take any medications?
- _____ Accutane
 - _____ Antibiotics
 - _____ Birth Control
 - _____
 - _____
 - _____

I have read and completed this questionnaire truthfully. 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 are voluntary and I release the company and/or skin care professional from liability.

Signature _____ Date _____

