

Client Information and Medical History

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is confidential.

Client Name: _____ Date of Birth: ____/____/____

Address: _____

Telephone: (____) _____ E-Mail: _____

Emergency Contact: _____ Telephone: (____) _____

Referred by: _____

How would you describe your skin? Normal/Combo Oily Sensitive Dry Mild Acne Moderate Acne Mature & Aging

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

- I Very fair skin; blond or red hair; light-colored eyes; freckles common; always burns, never tans
- II Fair skinned; light hair; light eyes; can burn, sometimes tans
- III Light to Olive Complexion; eye and hair color vary; burns moderately, tans easily
- IV Mediterranean Caucasian skin; medium to Dark Complexion; seldom burns, always tans well
- V Mideastern skin; brown Complexion; rarely burns, deep tan
- VI Dark Brown Complexion; rarely burns, deeply pigmented

Do you have a history of keloid scarring? Yes No

What are your goals for your skin? _____

What areas of concern do you have regarding your skin: (Please check any that apply) Breakouts/acne
 Blackheads/whiteheads Excessive oil/shine Rosacea Broken capillaries Redness/ruddiness
 Sun spots/brown spots Uneven skin tone Sun damage Wrinkles/fine lines Dull/dry skin
 Flaky skin Dehydrated skin Other _____

What skincare products do you use on a daily basis? Soap Cleanser Toner Scrub Masque
 Moisturizer Sunscreen SPF # _____ Other _____

What brand(s) skincare products are you currently using? _____

What makeup products are you currently using? _____

Do you wax your facial skin on a regular basis? Yes No If yes, when was the last time? _____

Have you ever had facials, chemical peels, microdermabrasion or any resurfacing treatments? Yes No
If yes, when? _____

Have you experienced Botox, Restylane or Collagen injections? Yes No If yes, when? _____

Are you currently using, or have you used in the past year, any of the following? Isotretinoin (Accutane)

Tretinoin (Retinoic Acid) Acyclovir Adapalene (Differin) Glycolic Acid Salicylic Acid
 Azelaic Acid Lactic Acid Hydroquinone Spironolactone Benzoyl Peroxide

If yes, when? _____

Health History

Are you currently or within the last year under any doctor's care? No Yes (explain) _____

Health Concerns:

Cancer Diabetes Epilepsy Heart High or low blood pressure Asthma HIV Hormone imbalance
 Thyroid Depression Eczema Dermatitis Metal implants Bleeding disorders Circulatory issues
 Vitiligo Melasma Smoking history Herpes Simplex (cold sores) Date of last outbreak _____

Do you have any allergies or sensitivities to: Medication Cosmetics Animals Pollen Latex Foods
 Iodine (shellfish) Other _____

Do you take any medications or vitamins? If so, please list. _____

Have you ever had a reaction to any facial treatments? No Yes (explain) _____

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe: _____

Have you been exposed to the sun or used a tanning bed in the last 48 hours? Yes No

How frequently are you exposed to the sun or use a tanning bed? Infrequently Frequently Regularly

Do you follow a regular exercise program? Yes No

What is your stress level? High Medium Low

Do you wear contact lenses? Yes No

Female Clients Only:

Are you currently pregnant? Yes No

Are you breastfeeding? Yes No

Have you experienced any of the following? Hysterectomy Menopause Hormone Replacement Therapy

Male Clients Only:

What is your current shaving system? Wet shave Electric

Do you experience irritation from shaving? Yes No Ingrown hairs? Yes No

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

May I email you to confirm future appointments? Yes No

May I contact you via text/mail/email about future promotions and news? Yes No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical and health conditions and to update this information at subsequent visits. 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.

Client Signature: _____ **Date:** _____