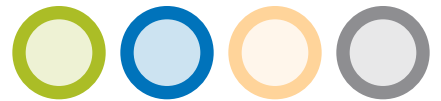


# Skincare History Questionnaire and Wavier



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:

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Have you ever had Herpes Simplex? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax® (Acyclovir) 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:

- |  |  |
|--|--|
| <input type="checkbox"/> Skin Cancer     | <input type="checkbox"/> Broken Capillaries  |
| <input type="checkbox"/> Dermatitis      | <input type="checkbox"/> Treatment Reactions |
| <input type="checkbox"/> Keloid Scarring | <input type="checkbox"/> Hypopigmentation    |
| <input type="checkbox"/> Acne            | <input type="checkbox"/> Hyperpigmentation   |
| <input type="checkbox"/> Rosacea         |  |

Do you have or have you had any of the following in the last 14 days?

- |  |  |
|--|--|
| <input type="checkbox"/> Facial Cosmetic Surgery | <input type="checkbox"/> Chemical Exfoliation (Peels)        |
| <input type="checkbox"/> Botox Injections        | <input type="checkbox"/> Extractions                         |
| <input type="checkbox"/> Collagen Injections     | <input type="checkbox"/> Permanent Cosmetics                 |
| <input type="checkbox"/> Fillers                 | <input type="checkbox"/> Waxing                              |
| <input type="checkbox"/> Light Treatments        | <input type="checkbox"/> Laser Hair Removal                  |
| <input type="checkbox"/> Laser Resurfacing       | <input type="checkbox"/> Hair Treatments (perm, color, etc.) |
| <input type="checkbox"/> Microdermabrasion       |  |

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

### Home Care:

What skincare products are you currently using at home?

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

**Please check if you are presently experiencing or have experienced 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)

### Prescription products:

- Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)
- Adapalene (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.