__Acne __Hyper Pigmentation
__Rosacea
41. In the past 14 days have you had any of the following:
__Facial Cosmetic Surgery __Chemical Exfoliation(Peels)
__Botox Injections __Extractions
__Collagen Injections __Permanent Cosmetics
__Fillers __Waxing
__Light Treatment __Laser Hair Removal
__Laser Resurfacing __Hair Treatments (Perm)

42. Please check if you are presently using of have used 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, Miro, Renova, Avita)
__Adepalene (Differin) __Azelaic Acid(Azelex, Finaccea)
__Tazarotene (Tazorac) __Isotrtinoin (Accutane)
__Triluma __Merogel
Any other topical antibiotics_____
43. When exposed to the sun do you:
__Always burns, never tan
__Always burns, sometimes tan
__Sometimes burn, sometimes tan
__ Always tan
Do you feel that your skin is sensitive? __Yes __No
44. Do you drink more than 4 caffeinated beverages daily? (Coffee, tea, soft drinks) __yes __no
45. Do you ever experience a burning, itching sensation on your skin? __yes __no
46. What is your pain threshold? __low __medium __high
47. What type of massage pressure do you prefer? __light __ medium __firm
48. What skin condition(s) do you want to improve?
__ Acne / Breakouts __ Rosacea
__Facial Scarring __Uneven Tone
__Hyper Pigmentation (freckles, age spots) __Uneven Texture
__Hypo Pigmentation __ Dehydration
__Enlarged Pores __Oily
__Fine Lines and Wrinkles __Sun Damaged
Is there any other necessary information your skincare specialists should know before beginning your treatment? __yes __no
If yes, please explain_____

Questions to discuss every visit

49. Are you currently having or due for your menstrual period? __yes __no
50. Have you started any new medication since your last visit? __yes __no
51. Have you had any recent dental x-rays? __yes __no
52. What are your skin care goals? _____

I understand that some skin conditions may require more than one treatment and home care products to achieve the results desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Signature_____ Date_____

Consultation for Face Treatments

Client Name _____ Date _____
Address _____ apt/unit _____
City _____ State _____ Zip _____
Email _____ @ _____
Telephone (home)(____)_____(work)(____)_____
Birthday month _____ day _____
_ Under 21 _ 21-30 _ 31-40 _ 41-50 _ 51-60 _ 60+
How did you hear about us? _____
To receive text reminders. Carrier:_____ Cell Phone#: ( )_____

Health History

1. Within the last year, have you been under a dermatologist's or other Physician's care? __ yes __ no
2. Within the last nine months, have you undergone any surgery? __ yes __ no
3. Have you had any health problem in the past or present? __yes __ no
If yes, please specify _____
4. List any medications, supplement, vitamins, diuretics, slimming tablets, ECT. That you take regularly.
_____
5. Do you smoke? __yes __no
6. Do you exercise regularly? __yes __no
7. Do you follow a restricted diet? __yes __no
8. Do you wear contact lenses? __yes __no
10. Rate your level of stress on a scale of 1to 5 (1=low stress, 5 = high stress) _____
11. Do you have any special skin problems pertaining to your face or body? __yes __no
If yes, Please specify_____
12. What is your genetic background? _____
13. How is your general health? __Excellent__Good__Fair__Poor
14. Please circle the following conditions if 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	Hearth Attack	Tooth Fillings
Fainting	Contact Leases	Claustrophobia	Varicose Veins	Epilepsy	High/Low Blood Pressure

Allergies

15. Have you ever had an allergic reaction to any of the following?
Aspirin or Salicylates __ Milk__ Apples __ Citrus __ Grapes__ Cosmetic__ Medicine__ Iodine__ Pollen __ Hydroxy Acids__ Animals__ Fragrance__ Sunscreens__ Sulfur__ Latex__
16. If yes to any of the above, please explain _____
17. Please list any other know allergies_____
18. Have you ever had Herpes Simplex? Yes___ No___
19.If yes, have you ever been treated with Denavir (Penciclovir) Zovirax (Acyclivor) or Abreva? Yes __ No __
20. Are you being treated for Hepatitis ? Yes ___ No ___

Female Clients Only

21. Are you taking oral contraception? __yes __no
22. Are you pregnant or trying to become pregnant? __yes __no
23. Are you lactating? __yes __no

Male Clients Only

24. What is your current shaving system? __electric __blade
25. Do you experience irritation from shaving? __yes __no
26. Do you experience ingrown hairs? __yes __no

Skincare History

27. What skin care products are you currently using?
Face: __soap __cleanser __toner __moisturizer __exfoliation __eye products
Body: __soap __ shower gel __scrubs __oil __body moisturizer __depilatory products __self tanners
28. Do you use Accutane, Retin-A, Renova, Adapalene or any other prescription skin products? __yes __no
In the last 3 months? __yes __no
29. How much plain water do you consume daily _____
30. How much alcoholic beverages do you consume weekly? _____
31.. Do you ever experience these conditions on your skin? __flakiness __ tightness __ obvious dryness
32. What SPF sunscreen do you use on your face? _____ body? _____
33. Do you sunbathe or use tanning beds? __yes __no
34. Do you burn easily in moderate sunlight? __yes __no
35. Do you blush easily when nervous? __yes __no
36. Do you have a tendency to redness? __yes __no
37. Do you suffer from sinus problems? __yes __no
38. Do you ever experience oily shine during the day? __yes __no
39. Do you ever experience skin breakouts? __yes __no
40. Please check if any of the following that apply:

__Skin Cancer	__Broken Capillaries
__Dermatitis	__Treatment Reactions
__Keloid Scarring	__Hypo Pigmentations