Skin Care History Questionnaire and Waiver

Please answer the following questions so that your Skin Care Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skin Care 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 ____________

____

Please see Contraindictions, page 44. Contact dermatologist to confirm treatment.

What is your genetic background? ______________________________________

How is your general health? ______ Excellent ______ Good ______ Fair ______ Poor

Please see Contraindictions, page 44.

Please rate your stress level from 1-5 (5 being the highest): __________

Please circle the following conditions you have or had experienced:

- hypertension
- metal plate
- diabetes
- fainting
- cold sores
- hernia
- stroke
- contact lenses
- anemia
- lupus
- irregular pulse
- claustrophobia
- cancer
- thyroid disorders
- high cholesterol
- varicose veins
- seizures
- eating disorder
- heart attack
- epilepsy
- headaches
- asthma
- hepatitis
- tooth fillings
- high/low blood pressure
- autoimmune disorder

These conditions may just need to be known or are a contraindiction to treatment. If treatment is questionable, contact a physician.

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 SKIN CARE PRODUCTS Yes________ No________

FISH, MARINE OR IODINE ALLERGIES Yes________ No________

LATEX Yes________ No________

If known allergy, refer to ingredient decks and perform patch test.

If checked yes to any of the above, please explain ____

____

____

Please list any other known allergies:

____

Have you ever had Herpes Simplex? Yes________ No_______

If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax® (Acyclivor) 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________

Are you pregnant or nursing? Yes________ No________

Consult with a physician, proper medication may be needed or may be contraindicted.

Skin Care 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:

________ Benzoyl Peroxide (BP)

________ Glycolic Acid (AHA)

________ Lactic Acid (AHA)

________ Resorcinol

________ Salicylic Acid (BHA)

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

________ Facial Cosmetic Surgery
________ Botox Injections
________ Collagen Injections
________ Fillers
________ Light Treatments
________ Laser Resurfacing
________ Microdermabrasion
Other ____

Higher risk of contraindiction.

HOME CARE:

What skin care products are you currently using at home?

Use of proper home care products are crucial to results. Incorporate pre and post treatment products.

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

PRESCRIPTION PRODUCTS:

________ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)
________ Adepalene (Differin®)
________ Azelaic Acid (Azelex®, Finacea™)
________ Tazarotene (Tazorac®)
________ Isotretinoin (Accutane)
________ Triluma™
________ Metrogel

Consult with a physician, as treatment may be contraindicted.

Any other topical antibiotics____

PLEASE CHECK IF YOU ARE PRESENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING:

________ Skin Cancer
________ Dermatitis
________ Keloid Scarring
________ Acne
________ Rosacea
________ Broken Capillaries
________ Treatment Reactions
________ Hypopigmentation
________ Hyperpigmentation

Confirm whether prescription, OTC or retail products are at proper levels, certain ingredients are needed while others may cause sensitivity or reaction at high concentrations.

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________

Chemical exfoliant treatments make skin sun sensitive. SPF is highly recommended.

WHEN EXPOSED TO THE SUN DO YOU:

________ Always burn, never tan
________ Always burn, sometimes tan
________ Sometimes burn, sometimes tan
________ Always tan

Helps determine Fitzpatrick Skin Type.

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

Helps esthetician understand expectations and create treatment plan.

OTHER ____

Is there any other necessary information your Skin Care 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:**______________________
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Client Signature: ______________________________ **Date:**______________________
Client Signature: ______________________________ **Date:**______________________

Have client review and sign before each appointment to acknowledge there have not been any changes.

○ Please check if permission is granted to use pictures for marketing and training purposes. Your name will remain anonymous.

Take pictures before and after treatment to monitor progress and for proper documentation.