SKINCARE HISTORY

Have you seen a Dermatologist in the past year? Yes No

If yes, list the reason for the 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 _____

Are you claustrophobic? Yes No

Do you wear contact lenses? Yes No

Do you have a tendency to scar? Yes No

Do you have sensitive skin? Yes No

Please circle the conditions you want to improve:

Acne and/or breakouts Hyperpigmentation (freckles, age spots) Enlarged pores

Fine lines and wrinkles Uneven tone/texture Rosacea Double chin

Other:_____

Medical History

Does your medical history include?

Hormonal Imbalance Radiation Keloid Scaring Other :_____

Do you have a family history of skin cancer, melanoma or other skin related diseases? Yes No

Have you ever had Herpes Simplex? Yes No

Are you being treated for Hepatitis? Yes No

Do you have epilepsy or diabetes? Yes No

Are you allergic to any foods or medications?:

Aspirin or Salicylates Milk Apples Fish, marine or iodine allergies Latex

Other: _____

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

Please circle treatments you have had in the past.

Facial Cosmetic Surgery Botox Injections Dermal Filler Injections

Skin Cancer Dermatitis Keloid Scarring

Laser Resurfacing Microdermabrasion Chemical Exfoliation (Peels)

Waxing Plucking Bleaching Laser Hair Removal

Other_____

Are you currently having skin treatments? Yes No If yes, what? _____

Home Care: What skincare products are you currently using at home?

Cleanser _____ Moisturizer _____

Toner _____ Eye Cream _____

Antioxidant _____ SPF _____

Exfoliants _____ Specialty Products _____

Over the Counter Products: If you are using, or have used, any of the following, please circle:

Benzoyl Peroxide (BPO) Sulfur Glycolic Acid (AHA) Minoxidil (Rogaine)

Lactic Acid (AHA) Vitamin C Salicylic Acid (BHA) Hydrocortisone (HC)

Resorcinol Vitamin A Hydroquinone (HQ) Sunless tanning

Prescription Products: If you are using, or have used, any of the following, please circle:

Adepalene (Differin®) Azelaic Acid (Azelex®, Finacea) Tazarotene (Tazorac®)

Isotretinoin (Accutane) Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)

Sun Protection:

Do you use a sunscreen? Yes No If so, what level of protection? _____

Do you sunbathe or participate in outdoor activities? Yes No

Do you tan in a tanning booth? Yes No

When exposed to the sun, do you:

Always burn, never tan Always burn, sometimes tan Sometimes burn, sometimes tan Always Tan

Is there any other information your skincare therapists 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, and I understand that some skin conditions may require more than one treatment and home care products to achieve the desired results.

Patient (or Legal Guardian): _____ **Date**: _____

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