CLIENT CONSULTATION

SKIN CARE HISTORY QUESTIONAIRE

Please answer the following questions so as to have a better understanding of your general health, lifestyle, and to accurately analyze, and assess your skin-care needs.

Date:____/_____/_____

Name: _____ **DOB:** _____/_____/_____
First Last M.I Month Day Year

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Please check if you are currently using any of the following products. (*please ✓check all that apply*)

❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid ❑ Topical Vitamin C ❑ Hydroquinone
❑ Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin

Which conditions do you want to improve? (*please ✓check all that apply*)

❑ Hyperpigmentation (Brown Sports) ❑ Acne/Acne Scarring ❑ Sun Damage ❑ Enlarged Pores
❑ Fine Lines & Wrinkles ❑ Age Spots ❑ Surgical Facial Scars ❑ Other: _____

_____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No

FEMALE CLIENTS

Are you on hormone-replacement therapy? ❑ Yes ❑ No
Are you presently taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No

ALL CLIENTS

Do you use a sunscreen/sunblock? ❑ Yes ❑ No
Do you sunbathe or participate in outdoor activities? ❑ Yes ❑ No
Have you seen a dermatologist in the past year or week? ❑ Yes ❑ No
If yes, list doctor's name and reason for visit _____

_____

Are you presently under a doctor's care? ❑ Yes ❑ No
What medications do you take on a regular basis?_____

_____

Have you ever had herpes (cold sores)? ❑ Yes ❑ No
Have you ever been treated with Zovirax or any other medication for herpes? ❑ Yes ❑ No

If yes, how recent? _____

SKIN CARE HISTORY QUESTIONAIRE (CONTD)

Do you have epilepsy or diabetes? ❑ Yes ❑ No
If yes, you will be treated only with a doctor's release
Do you use Blare or snore strips? ❑ Yes ❑ No

Have you had any of the following? (*please ✓check all that apply*)
❑ Cosmetic Surgery ❑ Botox Injections ❑ Skin Cancer ❑ Dermatitis ❑ Keloid Scarring
❑ Laser Resurfacing ❑ Chemical Peels ❑ Hepatitis ❑ Other (Specify) _____

If yes to the above , how recent? _____
Are you allergic to aspirin? ❑ Yes ❑ No
Are you allergic to iodine or seaweed ? ❑ Yes ❑ No
Do you have any allergic reactions? ❑ Yes ❑ No
If yes, list _____

Do you smoke? ❑ Yes ❑ No
Do you take nutritional supplements? ❑ Yes ❑ No
Are you on a diet? ❑ Yes ❑ No
Do you exercise ? ❑ Yes ❑ No
Do you wear contact lenses? ❑ Yes ❑ No
Have you had body treatments or facials before? ❑ Yes ❑ No
Are you currently having facials? ❑ Yes ❑ No
Have you had electrolysis or waxing in the past week? ❑ Yes ❑ No

Have you had permanent cosmetics? ❑ Yes ❑ No
If yes, where?_____

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

Which foundation are you currently using? (List brand) _____

*Which of our **Facials** or **Body treatments** are you desiring? _____

What improvements are you seeking for your face or body? _____

*Which brand's **facial cleanser** are you currently using? _____

*Which brand's **facial moisturizer** are you currently using? _____

*Which brand's **specific facial treatment** are you currently using? _____

SKIN CARE HISTORY QUESTIONAIRE (cont'd)

Do you have blackheads ? ❑ Yes ❑ No

Do you have whiteheads? ❑ Yes ❑ No

Is your acne painful? ❑ Yes ❑ No

Is your acne deep, red and swollen ? ❑ Yes ❑ No

Is your acne dark, and swollen ? ❑ Yes ❑ No

Is your acne scattered over your face? ❑ Yes ❑ No

Is your acne located in a specific area of the face? ❑ Yes ❑ No Where?

_____

Does your acne come with comedones (mild acne: combination of blackheads and whiteheads)? ❑ Yes ❑ No

Does your acne result in: (*please ✓ check all that apply*)

❑ Pustules ❑ Papules ❑ Nodules ❑ Cysts ❑ Acne Scarring

❑ Pitted Scars ❑ Saucer-Shaped Scars ❑ Nodules ❑ Other (Specify) _____

Are you currently taking / using any of the following Acne Medications or Treatments - Oral or Topical? : (Please check all that apply) :

Clindamycin ❑ Yes ❑ No If yes , how recent? _____

Doxycycline ❑ Yes ❑ No If yes , how recent? _____

Erythromycin ❑ Yes ❑ No If yes , how recent? _____

Tetracycline ❑ Yes ❑ No If yes , how recent? _____

Spironolactone ❑ Yes ❑ No If yes , how recent? _____

Isotretinoin ❑ Yes ❑ No If yes , how recent? _____

Azelaic acid (Azelex) ❑ Yes ❑ No If yes , how recent? _____

Tretinoin (Retin-A) ❑ Yes ❑ No If yes , how recent? _____

Adapalene (Differin) ❑ Yes ❑ No If yes , how recent? _____

Tazarotene (Tazorac) ❑ Yes ❑ No If yes , how recent? _____

Other…. ❑ Yes ❑ No If yes , list name (s): _____

Do you have **rosacea** ? ❑ Yes ❑ No

(*A chronic inflammation of the forehead, nose, eyelids, cheeks, chin, nose, with or without lumps and bumps.*)

Do you have **couperose** skin ? ❑ Yes ❑ No

(*red with broken capillaries on the face*)

Client Signature:

CLIENT CONSULTATION

Which Acne skin-care products are you currently using? List below :

_____

****IMPORTANT:**

Do you have inflamed areas ? ❑ Yes ❑ No _____

Are you pregnant ? ❑ Yes ❑ No _____

Are you wearing a pacemaker ? ❑ Yes ❑ No _____

Do you have heart problems ? ❑ Yes ❑ No _____

Do you have high blood pressure ? ❑ Yes ❑ No _____

Are you wearing metallic braces? ❑ Yes ❑ No _____

Are you an epileptic ? ❑ Yes ❑ No _____

Have you received / are now receiving any therapy for a life–threatening disease ? ❑ Yes ❑ No

If yes, list here:_____

****LASER Treatments & CHEMICAL PEELS**

Have you ever received a Salicylic Peel ? ❑ Yes ❑ No If yes , how recent? _____

Have you ever received a Glycolic Peel ? ❑ Yes ❑ No If yes , how recent? _____

Have you ever received any other AHA peel ? Treatment ❑ Yes ❑ No If yes , how recent? _____

_____

Have you ever received an IPL Treatment ? ❑ Yes ❑ No If yes , how recent? _____

Have you ever received a Fractional Laser Treatment ? ❑ Yes ❑ No If yes , how recent? _____

Have you ever received any other Laser Treatments? ❑ Yes ❑ No If yes , how recent?

Are you allergic to any herb, essential oil or plant oil? ❑ Yes ❑ No If yes, (please list):

_____

Thanks for providing the above information, which will be used to verify or customize your Facial or Body Treatment.

Please **sign, scan**, and **email** form to chavahspa@yahoo.com, or bring it with you when you come for your appointment.

Client Signature:

OFFICIAL USE ONLY:

Aesthetician: