

**Confidential Skin Health Survey**

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth/Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Phone H (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there someone we can thank for recommending us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

1. Please circle any conditions you currently have or have had in the past.

AIDS Hay Fever Radiation Treatment

Anemia Heart Disease Respiratory Problems

Arthritis Hepatitis Skin Conditions

Asthma/Allergies High Blood Pressure Sinus Problems

Autoimmune Disease Infection Stomach Problems

Blood Transfusion Kidney Disease Stroke

Chemotherapy Liver Disease Thyroid Problems

Cold sore/Fever Blister Lupus Surgery

Diabetes Melanoma Skin Cancer

Dizziness/Fainting Nervous Disorder CANCER OF ANY KIND

Epilepsy

2. **ALLERGIES**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Please list all current medications you are taking:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin History**

1. What is the reason for your visit today?

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2. What special areas of concern do you have?

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3. Are you presently under a physician’s care for any current skin condition or other problem?

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are you pregnant? **Y N**

5. Are you taking birth control pills or hormone replacement? **Y N**

6. Do you wear contact lenses? **Y N**

7. Do you smoke? **Y N**

8. What skin care products are you using now?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Have you used or are you currently using: (please circle)

Retin A or similar product

Accutane

Other prescription Acne medication

10. Have you ever had any of the following aesthetic or cosmetic services (please circle)

Facial Peel Laser/IPL Tattooing Facial Surgery

Microdermabrasion Botox Permanent Makeup Mesotherapy

Dermaplaning Fillers Waxing

If Yes, have you had any type of reaction to the procedure(s):

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11. Do you have acne?

If yes, what are you using or have you used in the past?

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12. Is there anything else we should know about your skin health or overall health?

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**DISCLAIMER**

I understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purpose only and not diagnostic or prescriptive in nature. I understand that the information contained is to aid the therapist in giving better service and is completely confidential.

**Policies:**

1. Professional consultation is required before initial dispensing of products.

2. We do not give cash refunds

3. We require a 24-hour cancellation notice.

I HAVE COMPLETED THIS SURVEY ACCURATELY AND COMPLETELY. I fully understand and agree to the above policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FOR STAFF USE ONLY:

**Skin Type** Normal Oily Dry Combination

**Condition** Texture Pigmentation

Sun Damage Rosacea

Acne Sensitivity

**Areas of Concern**

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