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

Anemia

Arthritis

Asthma/Allergies

Autoimmune Disease

Blood Transfusion

Chemotherapy

Cold sore/Fever Blister

Diabetes

Dizziness/Fainting

Epilepsy

Hay Fever

Heart Disease

Hepatitis

High Blood Pressure

Infection

Kidney Disease

Liver Disease

Lupus

Melanoma

Nervous Disorder

Radiation Treatment

Respiratory Problems

Skin Conditions

Sinus Problems

Stomach Problems

Stroke

Thyroid Problems

Surgery

Skin Cancer

CANCER OF ANY KIND

2. **ALLERGIES**

____

3. Please list all current medications you are taking:

____

____

Skin History

1. What is the reason for your visit today?

____

2. What special areas of concern do you have?

____

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):

____

11. Do you have acne?

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

____

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

____

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:

Areas of Concern

____

____