CONFIDENTIAL SKIN HEALTH HISTORY

Name: _____ Date:_____

PERSONAL INFORMATION: Age:_____ DOB:_____

Address:_____City:_____State_____ZIP_____

Phone #: (Home)_____ Cell_____

E-mail_____
Would you like to receive our cosmetic e-mails with specials and information? Y N

Occupation:_____ Ethnic Background:_____

HEALTH HISTORY:
Are you currently taking any medications? Please list: _____

Have you seen a dermatologist in the last five years? Y ☐ N ☐

Are you a smoker? Y ☐ N ☐

Are you allergic to or ever had an allergic reaction to any products or ingredients? Y ☐ N ☐

If yes, please list _____

Pregnant? Y ☐ N ☐ Nursing? Y ☐ N ☐ Drink Alcohol? Y ☐ N ☐ Amount per day?_____

Eat a lot of sugar? Y ☐ N ☐ Consume caffeinated beverages? Y ☐ N ☐ How many per day?_____

Indoor/Outdoor tan? Y ☐ N ☐ How often?_____ How much water do you drink a day?_____

How often do you exercise?_____ Your daily stress level: ☐Mild/Low ☐Medium/Average ☐High/Intense

Please check any of the following you are currently being treated for or have been treated for in the past:

☐ Auto – Immune Disorders	☐Take birth control	☐Mental Disease	☐Metal implants
☐Cancer	☐Heart Disease	☐Neuro-muscular	☐Hormone replacement
☐ Cold Sores/ Fever Blisters	☐High Blood Pressure	☐Take Accutane	☐Allergies
☐ Diabetes	☐Liver Disease	☐Skin Problems	

YOUR SKIN:
Do you currently suffer from any skin conditions?_____

How would you describe your skin? ☐DRY ☐NORMAL ☐SENSITIVE ☐ACNE PRONE ☐OILY

Rate how you feel about the overall look of your skin (1=horrible 10=fantastic): _____

If you go in the sun without sunscreen, how often will you burn?
☐Always ☐Sometimes ☐Often ☐Rarely ☐Never

When was your last sunburn?_____ Use of tanning beds? Y☐ N☐ How often?_____
How often do you wear facial sunscreen? ☐EVERYDAY ☐OCCASSIONALLY ☐ONLY WHEN OUTSIDE

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Please list any cosmetic procedures you have had in the last 12 months:_____

Have you received any facial waxing services in the past 1-3 days prior to this visit? Y ☐ N ☐
Have you used any harsh exfoliants on your skin in the past 1-3 days prior to this visit? Y ☐ N ☐

PRODUCTS:

		NAME/TYPE: Drugstore/Department/Professional
Cleanser	Yes ☐ / No ☐	
Toner/Astringent	Yes ☐ / No ☐	
Moisturizer	Yes ☐ / No ☐	
Sunscreen	Yes ☐ / No ☐	
Treatments/Serums	Yes ☐ / No ☐	
Eye cream	Yes ☐ / No ☐	
Other	Yes ☐ / No ☐	

What would you like to achieve/gain from your visit today?_____

What is the most important improvement you would like to see in your skin?_____

I understand the above information is true and accurate to the best of my knowledge. If in any case this information changes I will notify my practitioner. I understand that all known allergies should be described to the Esthetician and they are not held responsible for any adverse reactions to products during my service. I understand that the Esthetician is responsible for determining the best treatment method for my skin and therefore, if necessary my treatment can be terminated at any time. I understand that there is a 24 hour cancellation policy and that if I fail to give adequate notice I will be charged for 50% of the missed session. I also understand that all information stated is strictly confidential and will not be shared outside of this facility due to HIPPA regulations.

_____ _____
Patient Signature Date

Submit