



SKIN CARE HISTORY QUESTIONNAIRE

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin-care needs.

Name (please print clearly) _____ Date _____ / _____ / _____
Date of Birth _____ / _____ / _____

First _____ Last _____ M.I. _____
Street Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ E-Mail Address _____

Please check if presently using any of the following. (please ✓ 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 ✓ all that apply)

Hyperpigmentation (Brown Spots) 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 or planning to be? Yes No

ALL CLIENTS

Do you use a sunscreen/sunblock? Yes No
Do you sunbathe or participate in outdoor activities? Yes No
Do you have or have you ever had acne? Yes No
Are you using or have you ever used any medications for acne? Yes No
Name of medication _____

Have you seen a dermatologist in the past year? 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 medication for herpes? Yes No

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Do you have epilepsy or diabetes? Yes No

If yes, you will be treated only with a doctor's release!

Do you use Biore, Snore Strips, or any other Medical Apparatuses? Yes No

Have you had any of the following? Yes No *(please ✓ all that apply)*

Cosmetic Surgery Botox Injections Skin Cancer Dermatitis Keloid Scarring

Laser Resurfacing Chemical Peels Hepatitis Other (Specify) _____

Are you allergic to aspirin? Yes No Are you allergic to iodine or seaweed? Yes No

Do you have any other allergies? 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 skin treatments (facials) before? Yes No

Are you currently having facials? Yes No

Have you had electrolysis or waxing in the past week? Yes No

Do you have those services done regularly? Yes No

Have you had permanent cosmetics? Yes No

If yes, where? _____

How is your general health? Excellent Good Fair Poor

What skin-care products are you currently using? _____

What is it about your skin you would like to change? _____

Is there any other information I should know before beginning your treatment? _____

Client
Signature

BEAUTY
BAR SALON &
MED SPA

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