## Skin Care Patient Profile

Name _____ DOB _____

Address _____ Apt _____

City _____ State _____ Zip _____

Phone _____

Email _____

Referred By _____

## Your Health

Within the last year, have you been under a dermatologist's or other physician's care? □ yes □ no

Within the last nine months, have you undergone any surgery? □ yes □ no

If yes, please specify _____

Have you had any health problems in the past or present? □ yes □ no

If yes, please specify _____

List any medications, supplements, vitamins, diuretics, slimming tablets, etc. that you take regularly.

_____

Do you smoke? □ yes □ no

Do you exercise regularly? □ yes □ no

Do you follow a restricted diet? □ yes □ no

Do you wear contact lenses? □ yes □ no

Do you have metal implants, a pacemaker or body piercings? □ yes □ no

Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress) _____

## Your Skin

Do you have any special skin problems pertaining to your face or body? □ yes □ no

If yes, please specify _____

What skin care products are you currently using?

Face: □ soap □ cleanser □ toner □ moisturizer □ masque □ exfoliator □ eye products

Body: □ soap □ shower gel □ scrubs □ oil □ body moisturizer □ depilatory products □ self tanners

## Exfoliation History

Have you ever had chemical peels, microdermabrasion, or any other resurfacing treatments? □ yes □ no

Within the last month? □ yes □ no

Do you use Accutane, Retin-A, Renova, Adapalene or any other prescription skin products? □ yes □ no

Within the last 3 months? □ yes □ no

Are you currently using any products that contain the following ingredients?

□ glycolic acid □ lactic acid □ any exfoliating scrubs □ any hydroxy acid product □ vitamin A derivatives (i.e., retinol)

## Moisture Hydration

How much plain water do you consume daily? _____

How many alcoholic beverages do you consume weekly? _____

Do you ever experience these conditions on your skin? □ flakiness □ tightness □ obvious dryness

What spf sunscreen do you use on your face? _____ Body? _____

Do you sunbathe or use tanning beds? □ yes □ no

## Capillary Activity

Do you burn easily in moderate sunlight? □ yes □ no

Do you blush easily when nervous? □ yes □ no

Do you have a tendency to redness? □ yes □ no

Do you suffer from sinus problems? □ yes □ no

## Oil Secretion

Do you experience oily shine during the day? □ yes □ no

Do you ever experience skin breakouts? □ yes □ no

## Nerve Activity

Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) □ yes □ no

Do you ever experience a burning, itching sensation on your skin? □ yes □ no

What is your pain threshold? □ low □ medium □ high

Have you ever experienced claustrophobia? □ yes □ no

What type of massage do you prefer? □ light □ medium □ firm

Have you ever had a reaction to any of the following?

□ cosmetics □ medicine □ iodine □ food □ pollen □ fragrance □ animals □ sulfur □ milk □ apples

□ citrus □ grapes □ aloe vera □ aspirin □ mushrooms □ bee products □ hydroxy acids □ sunscreens

□ other _____

## Female Clients Only

Are you taking oral contraception? □ yes □ no

Are you pregnant or trying to become pregnant? □ yes □ no

Are you lactating? □ yes □ no

## Male Clients Only

What is your current shaving system? □ electric □ blade

Do you experience irritation from shaving? □ yes □ no

Do you experience ingrown hairs? □ yes □ no

## Questions to Discuss Every Visit

Are you currently having or due for your menstrual period? □ yes □ no

Have you started any new medication since your last visit? □ yes □ no

Have you had any recent dental x-rays? □ yes □ no

What are your skin care goals? _____

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client Signature _____ Date _____