Confidential Skin Care Questionnaire

Today's Date _____ Date of Birth_____
First Name_____ Last Name_____
Street Address_____
City_____ State_____ Zip_____
Home Phone_____ Alternate Phone_____
Emergency Contact Person_____ Phone_____
Email address: _____
Occupation: _____

Health Care

1. What are your skin care concerns? _____
2. Please indicate ethnic origin of your parents: _____
3. Are you pregnant? ( ) yes ( ) no
4. Are you nursing? ( ) yes ( ) no
5. Are you taking birth control? ( ) yes ( ) no
6. Are you taking hormone replacement? ( ) yes ( ) no
7. Do you wear contact lenses? ( ) yes ( ) no
8. Are you currently under a physicians care for your skin or wellness? ( ) yes ( ) no
9. Are you currently taking any antibiotics oral or topical? ( ) yes ( ) no
10. Have you had skin cancer? ( ) yes ( ) no
11. Do you have any allergies to any products? ( ) yes ( ) no
    If so, please indicate: _____
12. Are you allergic to Sulfur or Sulfa? ( ) yes ( ) no
13. Do you have any metal implants? ( ) yes ( ) no
    If so, where? _____
14. Do you smoke? ( ) yes ( ) no
15. Do you consume alcohol regularly? ( ) yes ( ) no
16. Do you participate in vigorous sports or aerobic activities? ( ) yes ( ) no
    How often: _____ per week
17. Have you had hives, keloids, hypertrophic scarring? ( ) yes ( ) no
18. Are you concerned about any unsightly facial scarring (acne, trauma, etc) or birthmarks (PortWine Stain)? _____

Please indicate if you have been affected or have had the following:

HIV/AIDS	Claustrophobia	Autoimmune Disorders
Allergies	Urinary or Kidney	Thyroid Problems
Asthma	Problems	Pacemaker
Heart Problem	Cancer	Psychological Problems
Eczema	Hepatitis C	Ringworms
Epilepsy	Herpes	Radiation Treatment
Cold Sores	High Blood Pressure	Sinus Problem
Chronic Headaches	Hysterectomy	

Skin Care

19. Do you currently use wax, electrolysis, or depilatories on your face? ( ) yes ( ) no
    If so, when was your last treatment? _____
20. Have you used or currently using Accutane? ( ) yes ( ) no
    If so, when? _____
21. Have you ever used Hydroquinone? ( ) yes ( ) no
    If so, when? _____
22. Are you currently using products containing Glycolic Acid, AHA, or Retin-A? ( ) yes ( ) no
23. Have you visited a tanning booth within the past 3 months ( ) yes ( ) no
25. Do you have permanent Make-Up? ( ) yes ( ) no
    If so, where? _____

Have you had any of the following?

Microdermabrasion	( ) yes	( ) no	If so, when_____
Laser Resurfacing	( ) yes	( ) no	If so, when_____
Collagen or Botox	( ) yes	( ) no	If so, when_____
Cosmetic Surgery	( ) yes	( ) no	If so, when_____
Chemical Peels	( ) yes	( ) no	If so, when_____

Consent Agreement

I affirm that I have stated all known medical conditions and the above information is correct. I agree to keep the Aesthetician updated as to any changes in my medical profile and understand there shall be no liability to Skin Fetish should I fail to do so.

Client's Signature: _____ Date: _____

Aesthetician's Signature: _____ Date: _____