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Name_____

Address_____**City**_____**State**_____

Zip_____ **Phone (h)** _____**(C)**_____

E-mail Address _____**DOB**_____

Within the last year, have you been under a dermatologist or other physicians care?_____
Within the last nine months, have you undergone any surgeries If yes, please specify:

_____
Have you had any health problems in the past or present? If yes, please specify:

_____

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, pacemaker or body piercings?
Yes No

Please list any medications, supplements, vitamins, diuretics, slimming tablets, etc that you take regularly?

_____

_____

Do you ever experience skin breakouts?	Yes	No
Do you ever experience oily shine during the day?	Yes	No

Do you ever experience a burning, itching sensation on your skin?
Yes No

Do you drink more than 4 caffeinated beverages a day?
Yes No

Have you ever experienced a reaction to any of the following? Cosmetics, medicine, iodine, pollen, food, animals, fragrance, hydroxy acides, sunscreens, other:_____

_____

Are you pregnant or trying to become pregnant?	Yes	No
Are you taking oral contraceptives?	Yes	No
Are you lactating?	Yes	No
What is your current shaving system?	Yes	No

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Do you experience irritation from shaving? Yes No
Do you experience ingrown hairs? Yes No
Are you currently having or due for your menstrual period?
Yes No

What are your skin care goals?

_____

_____

Do you have any special skin problems pertaining to your face or body?_____

_____

What skin products are you currently using?
Soap Cleanser Toner Moisturizer Masque
exfoliator eye products

Do you use Accutane, Retin A, Renova, Adapalene or any other prescripting skin products? If yes, please list:_____

Are you currently using any products that contain the following ingredients?
Glycolic acid Lactic acid Exfoliating scrubs
Hydroxy acids vitamin A derivatives

Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? If yes, how long ago?

_____

Do you get oily during the day? Yes No
What SPF sunscreen do you use on your face? _____
Do you sunbathe or use tanning beds? yes No
Do you burn easily in moderate sunlight? Yes No
Do you suffer from sinus problems? yes No
Do you experience redness regularly? yes No

I hereby agree to all of the above information and agree to the treatment about to be performed on me. I furthur agree to follow after treatment instructions by my skin care therapist. I understand the treatment i will be receiving and release “release spa studio” of all liability.

Signature: _____Date:_____