

Name: _____

Birthdate: _____ Referred By: _____

PERSONAL DATA:

1. Do you smoke? Yes or No
2. Do you suntan? Yes or No
3. Are you pregnant? Yes or No
4. Are you on any medications? Yes or No If so, please list _____
5. Do you have any allergic reactions to medications or skincare products? Yes or No If yes, please explain: _____
6. Have you had laser resurfacing or facial plastic surgery in the past 6 months?
Yes or No
7. Are you now using the Acne drug Accutane? Yes or No
9. Are you susceptible to cold sores? Yes or No
10. Do you currently use any form of hair removal on your face such as waxing, electrolysis or laser? Yes or No If so, which one? _____
11. Do you have any special skin concerns? If so please list. _____

HOME SKIN CARE PRODUCTS:

Please list the products you are currently using.

Cleanser _____ Toner _____ Foundation _____

Moisturizer _____ Eye Cream _____ Concealer _____

Sunscreen _____ Exfoliator _____ Other _____

