Skin Care History Profile

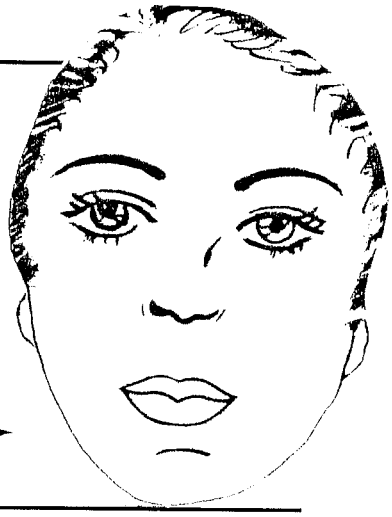
First Name: _____ Last _____ Birthday _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home _____ Work: _____ Cell: _____
Referred by: _____ Occupation _____

Describe your skin and specific conditions:

1. Acne / Scarring / Pimples
2. Blackheads
3. Coupe rose (broken capillaries)
4. Dehydrated flaky/ Dry
5. Fine lines / Wrinkles
6. Hyper pigmentation / Blotchy
7. Loss of elasticity
8. Milia / Whiteheads
9. Oily / Enlarged pores
10. Puffiness (water retention)
11. Psoriasis / Eczema
12. Sensitive / Redness / Rosacea
13. Sun damage / Freckles

Other _____

(write the number of the condition in the area of the face where it applies.)



Are you allergic/sensitive to? (Circle all that apply)
Milk apples citrus grapes aloe vera aspirin perfumes latex hydroquinone mushrooms
Alcohol based products **List any other allergies** _____

Have you ever had any of the following? (Please note last date and how often)
Botox injections _____ Collagen injections _____ Chemical peels _____
Facials _____ Microdermabrasion _____ Face surgery/Implants _____
Hair removal by hot wax / Electrolysis / Laser _____ Other _____

Have you or are you using any of the following? (Circle all that apply)
Accutane Antibiotics Antihistamines Biore/Snore Strips Birth Control Blood Thinners
Chemotherapy Differin Hormones Retin-A Renova Steroids Other _____

Are you or have you experienced any of the following health conditions: (Circle all that apply)
Alcoholism Hepatitis Hormonal Disorders Cancer Heart problems Menopause Pregnancy
Cold sores/fever blisters Thyroid Diabetes High/Low blood pressure Metal Implants Other _____

In your typical day do you? _
Wear contact lenses? **Y N** Exercise regularly? **Y N** Have irregular sleep patterns? **Y N**
Drink 8 glasses of water? **Y N** Consume alcohol? **Y N** Consume drinks high in caffeine? **Y N**
Diet or have poor eating habits? **Y N** Undergo a lot of stress? **Y N** Smoke? **Y N**
Have a skin care routine? **Y N** Spend time outdoors? **Y N** Have tendencies to burn? **Y N**
Use tanning beds? **Y N** How often _____ Use sunscreen/sun block? **Y N** What SPF _____

What is your hereditary background? _____
Describe your daily home care regimen? _____
Are there any new treatments you've heard of that you would like more information on?

_____

What are the cosmetic improvements you would like to see in your skin?

_____

Getting and keeping beautiful skin is not an event, but rather a journey that changes over time. We want to help you improve your skin and slow down the aging process, not just for today, but for life.

Date _____ **X** _____