SpectacularSkin

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

DATE _____
NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
HOME PHONE _____
WORK PHONE _____
CELL _____
EMAIL_____
OCCUPATION _____
REFERRED BY _____

MEDICAL INFORMATION

DATE OF BIRTH_____AGE_____FAMILY PHYSICIAN_____
DO YOU SMOKE?_____2ND HAND SMOKE?_____
HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)
◯ACNE ◯ DEPRESSION ◯ SKIN DISEASE ◯ HIGH BLOOD PRESSUE
◯COLDSORES ◯ DIABETES ◯ CANCER
LIST OF ALL ALLERGIES/ALLERGIC_____
_____
LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING_____
_____
ARE YOU PREGNANT?_____ TRYING TO GET PREGNANT?_____ HORMONE THERAPY?
ARE YOU PRONE TO COLD SORES?_____

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY?_____ DO YOU TAKE SUPPLEMENTS/VITAMINS?_____
DO YOU EXERCISE? _____IF SO, HOW OFTEN:_____ YOUR LAST SUNBURN?_____ DO YOU USE TANNING BEDS?_____
WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE CHECK ONE):
◯ALWAYS BURN (I) ◯ USUALLY BURN (II) ◯SOMETIMES BURN(III) ◯ RARELY BURN (IV) ◯VERY RARELY BURN (V) ◯NEVER BURN (VI)
HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:
◯DERMATOLOGIST ◯PLASTIC SURGEON ◯ESTHETICIAN ◯WOULD YOU BE INTERESTED IN COSMETIC SURGERY?_____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)
◯SUN SPOTS ◯SKIN LAXITY ◯ DRY / ROUGH
WHAT SKIN LINE ARE YOU CURRENTLY USING?_____
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)?_____ IF NOT, WHY?_____
CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):
◯ NORMAL ◯DRY/DEHYDRATED ◯OILY
◯ ACNE/ACNE ◯PRONE ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:
__REDUCTION OF FINE LINES
__REDUCTION OF BROWN SPOTS/SUN DAMAGE
__REDUCTION OF OIL/ACNE
__ACNE SCARS DIMINISHED
__REDUCTION OF REDNESS

TREATMENT PLAN *(TO BE COMPLETED BY PHYSICIAN / ESTHETICIAN)*

PROFESSIONAL TREATMENT RECOMMENDATION
◯ORMEDIC LIFT ◯LIGHTENING LIFT ◯ACNE LIFT ◯ IMAGE PERFECTION LIFT
◯SIGNATURE LIFT ◯WRINKLE LIFT ◯ACNE ADVANCED LIFT ◯ TCA LIFT

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: _____ **DATE:** _____