



THE PROFESSIONAL SKIN CARE DIVISION OF NORTH VALLEY DERMATOLOGY

SKIN CARE HISTORY QUESTIONNAIRE

Please answer the following questions so that I, your aesthetician, may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin care needs.

Date ___/___/___

Name (Last) _____ (First) _____ (M.I.) _____

Birth date _____ Age _____ Sex: M _____ F _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone # _____ Mobile# _____

Occupation _____ Referred By _____

Emergency Contact _____ Relationship _____ Phone# _____

Please check if presently using any of the following? (Please all that apply)

Accutane Glycolic Acid/Alpha Hydroxy Acid Topical Vitamin C

Hydroquinone Retinoid (vitamin A derivatives) i.e, Retin A, Renova, Differin

Which condition would you like to improve? (please all that apply)

Hyperpigmentation (Brown Spots) Acne/Acne Scarring Sun Damage Fine Lines & Wrinkles

Other: _____

Have you ever had an allergic reaction to any skin products or cosmetic? Yes No

Female Clients

Are you on hormone replacement therapy? Yes No

Are you presently taking birth control pills? Yes No

Are you pregnant or planning to be? Yes No

All Clients

Do you use a sunscreen? Yes No

Do you sunbath or participate in outdoor activities? Yes No

Do you have or have ever had acne? Yes No

Are you using or have ever used any medication for acne? Yes No

Name of medication/s? _____

Are you presently under a doctor's care? Yes No

What medications do you take on a regular basis? _____

Have you ever had cold sores? Yes No

Have you had any of the following? Yes No (Please ✓all that apply)

Cosmetic Surgery Botox Injections Skin Cancer Dermatitis Keloid Scarring

Laser Resurfacing Chemical Peels Microdermabrasion Diabetes Hysterectomy

Hormonal Imbalance Other (specify) _____

Are you allergic to aspirin? Yes No

Do you have any other allergies? Yes No

If yes, list _____

Do you smoke? Yes No

Do you take nutritional supplements? Yes No

Are you on a diet? Yes No

Do you exercise? Yes No

Do you wear contact lenses? Yes No

Have you had skin facials before? Yes No

Have you had electrolysis before? Yes No

Have you had any facial waxing? Yes No

Have you had permanent cosmetics? Yes No

If yes, where (eyebrows, lips etc...)? _____

How is your general health? Excellent Good Fair Poor

What skin care products are you currently using? _____

What is it about your skin you would like to change? _____

Is there any other information I should know before beginning your treatment? _____

I acknowledge that the above information is accurate, complete and vital for providing effective treatment. I understand incomplete information may result in unexpected reactions or negative results. I also understand a 24 hours cancellation notice is required, or I will be charged for the missed service.

I hereby agree to accept my financial responsibility for all charges incurred in the course of my treatment. Should collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney's fees.

Signature of Patient/Responsible Party _____ Date ____/____/____

CONSENT FOR TREATMENT

I understand clinical results may vary depending on skin type, skin condition, age, health, sun exposure, skin care habits, home care products and location of treatment.

I understand that skin is an organ that is constantly growing and changing so treatment progress and reactions will also vary, therefore no guarantees as to the results can be made.

I understand sun exposure is ultraviolet radiation and can result in further damage; therefore, sunscreen with SPF 15 to 30 is mandatory. Sunscreen application is recommended 15 minutes prior to sun exposure in order for sunscreen to bond with the skin and give optimum protection. Reapplying is necessary every 3 to 4 hours with prolonged exposure.

I understand there are possible side effects with resurfacing treatments such as temporary discoloration, redness, stinging, tightness, peeling or a prickling sensation. Skin may also feel warm, or uncomfortable, while healing. Alpha hydroxyl, Retin A, or any exfoliating or resurfacing home care products should not be used while healing.

I understand cold sore are stimulated with resurfacing treatments and a prescription medication may be required in severe cases.

To achieve maximum results, I may need several treatments and proper home care is required. Home care products greatly affect the condition, appearance, health of the skin and speed of the progression from professional treatments; optimum results are achieved with both professional treatments and good home care.

Prior to receiving treatment, I have been honest and accurate in revealing any condition or factors that may have a bearing on these treatments. I further agree to follow all post-care instructions as I am directed by the aesthetician. I hereby understand all of the above and agree to treatment.

Print Name: _____

Signature: _____

Date: _____

Aesthetician: _____

Date: _____