Facial Intake Form

Name: _____

Date: _____

Birthdate: _____

Address: _____

City, State, Zip: _____

Cell phone: _____

Referred by: _____

Email: _____

Pregnant? _____

Is this your first facial treatment? _____

What is the reason for your visit? _____

What are the specific areas of concerns?

_____

_____

Are you under a physician's care for a skin condition? _____

Are you on birth control pills currently? if yes please list.

_____

Are you on a hormone replacement? If yes please list.

_____

Do you wear contact lenses? _____

Do you experience stress often? _____

Have you been diagnosed with skin cancer? _____

Are you using; acutane, azelex, differin renova, retin-a, tazarac, glycolic or alpha hydroxy acids? How long have you been using each of the following?

_____

_____

Do you have acne? If yes for how long? _____

Do you experience frequent blemishes? If yes for how long? _____

Do you have allergies? Please list.
_____

Are you taking any other medications? Please list.
_____

_____

Are you using any of the following products (please circle); soap, cleansing milk, toner, scrub, mask, cream, sunscreen, other_____

What is your daily water consumption? _____

Do you experience any of the following (please circle)? Flakiness, tightness, obvious dryness?

Do you experience oily skin or shine during the day? _____

Is your menstrual period occurring now or soon? _____

Are you currently taking any new medications?
_____

Do you suffer from any of the following (please circle)? Asthma, cardiac problems, eczema, epilepsy, fever blisters, headaches, chronic, hepatitis, herpes, or high blood pressure

Have you had (please circle) a hysterectomy, immune disorder, lupus, metal bones, pins or plates, pacemaker, psychological problems, skin diseases? Please list.
_____

Any other concerns not listed here that should be noted?
_____

_____

_____