

Waxing Assessment Form

Date: _____

Name: _____

Address: _____

Phone Number: _____

Email: _____

Birthday: _____

Have you been seen by a dermatologist? Y N
If yes, for what reason? _____

Please list all medications that you take regularly.

Do you use Retin-A, Renova, or other topical vitamin A, or hydroquinose?
Y N If yes for how long? _____

Are you pregnant or lactating? Y N

Have you had any of the following procedures?

Laser Resurfacing Y N

Light Chemical Peel Y N

Med/Heavy Chemical Peel Y N

Do you have a history of fever blisters or cold sores? Y N

Are you using any exfoliant or hydroxy-based products? Y N

Disclaimer: Dan Chisholm is not responsible for any injury or allergic reaction(s) on any skin abrasion as a result of the service(s) on premise. I understand that all services are performed with my informed consent.

[] Yes, I agree