

Facial Health History Form

Section 1: Personal Information

Name: _____ D.O.B. ____ / ____ / ____ Sex: M F

Mailing Address: _____ Height: _____ Weight: _____

Occupation: _____

City

State

Zip

E-mail: _____

Phone: (Day) _____ (Evening) _____ (Cell) _____

Please List Your Preferred Contact Number: _____

Emergency Contact Person: _____

Relationship: _____ Phone: _____

Have you ever had a facial before? _____

When was your last facial? _____

How did you hear about our service? _____

Referred By: _____

What is your primary reason for making this appointment? _____

Section 2: Medical Information

Are you currently under a physician's care? _____

If yes, please explain _____

Family Doctor: _____ Phone: _____

Other Health Practitioners: _____ Phone: _____

Are you presently taking any medications (internally or topically)? _____ If yes, please list the medications and what they are prescribed for.

1. _____

2. _____

3. _____

Allergies: Please list any known allergies since certain products contain ingredients that can cause allergic reactions, e.g. latex, iodine, seaweed, wheat, etc.

1. _____

2. _____

3. _____

Previous Surgeries: Please list any surgeries (including cosmetic) you have had, and the date of the surgery.

1. Surgery: _____ Date: _____

2. Surgery: _____ Date: _____

3. Surgery: _____ Date: _____

Section 3: Life Style Information

Level of Personal Stress (1-10) _____

Do you get 8 hours of sleep at night? _____

Do you drink caffeinated beverages? _____ Number per Day: _____

Do you drink alcoholic beverages? _____

How much water do you drink daily? Number of glasses per Day: _____

Do you drink milk? _____ Number of glasses per Day: _____

Do you eat peanut butter? _____

Do you eat a lot of fish? _____

Do you salt your food? _____

Do you smoke? _____

Please list your skin care products and cosmetics that you use: _____

Please list any supplements your take: _____

How much sun exposure do you receive? _____

Do you suffer from any of the following problems, or experienced any of the following services? Please use a "Y" for a yes response, and a "N" for a no response. Please answer all questions thoroughly and honestly. We are not here to judge you; all information you provide is kept completely confidential, but to avoid any contraindications that could negatively affect your treatment, we must be fully informed.

Personal Concerns

- Whiteheads
- Blackheads
- Oily Complexion
- Dehydration
- Rosacea
- Fine Lines
- Wrinkles
- Eczema
- Psoriasis
- Pigmentary Discoloration
- Age Spots
- Moles
- Warts
- Dry Scalp
- Ingrown Hairs
- Broken Capillaries
- Cellulite
- PMS
- Menopause
- Pregnancy - Trimester _____

Procedures & Services

- Facials– From an Esthetician
- Glycolic Peels
- Jessners Peels
- TCA Peels
- Salicylic Peels
- Laser Hair Removal
- Micro-Dermabrasion
- Medical Dermabrasion
- Waxing
- Lash/Brow Tinting
- Body Wraps
- Endermologie
- Oxygen Facials
- Massage
- Makeovers

I have answered all of the above questions fully and honestly.

Signature: _____

Date: _____