

**AESTHETICAN SKIN CARE INFORMATION**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Resident Phone ( ) \_\_\_\_\_ Cell phone/Pager ( ) \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business ( ) \_\_\_\_\_

*Who may we contact in case of an emergency or if we need to change an appointment and cannot reach you?*

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ **Medical History** \_\_\_\_\_

Current medications, homeopathic drugs and vitamins \_\_\_\_\_

Do you have any drug or other allergies? YES or NO

If yes, please list them \_\_\_\_\_

Do you use or have you used any of the following:

RETIN-A \_\_\_\_\_ ACCUTANE \_\_\_\_\_ GLYCOLICS \_\_\_\_\_ DIET PILLS \_\_\_\_\_  
ORAL CONTRACEPTIVES \_\_\_\_\_

When did you take these? \_\_\_\_\_

Have you had an allergic reaction to a skin care product(s)?

Comment: \_\_\_\_\_

Check if you are allergic to, the following? \_\_\_\_\_ Sulpher \_\_\_\_\_ Collagen \_\_\_\_\_ Citrus/ Botanical

Do you sunbathe? \_\_\_\_\_ Yes \_\_\_\_\_ No

How often? \_\_\_\_\_

What SPF protection do you use? \_\_\_\_\_



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Have you seen a Dermatologist within the last 5 years?  Yes  No

Are you under his / her care now?  Yes  No

If yes, doctor's name and phone number : \_\_\_\_\_

Do you blush easily?  Yes  No

Have you ever had a reaction to any treatments?  Yes  No

Please explain: \_\_\_\_\_

Do you wear contact lenses?  Yes  No

Do you ever experience any skin break-outs?  Yes  No

Does PABA affect you in any way?  Yes  No

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**CHECK THE ITEMS YOU USE REGULARLY**

eye makeup remover     soap     cleanser     toner/astringent  
 day cream     night cream     scrub/exfoliant     concentrate/ampoule  
 eye cream     mask     sunscreen     other

Any special skin problems?  flaking     tightness     oily/dry skin  
 dermatitis     rosacea     acne

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**General History**

Any specific health problems?  Diabetes  Thyroid  Heart  Cancer  Hysterectomy  Epilepsy  
 Hormone Imbalance  Diet  HIV  Hepatitis  Herpes  Keloid  
 Headaches/Migraines  Skin infections or boils  Hypertension

When was your last menstrual period? \_\_\_\_\_

Might you be pregnant? \_\_\_\_\_

Current Medications, Homeopathic Drugs and Vitamins: \_\_\_\_\_

What is your daily consumption of: Water  Coffee  Tea  Soft Drinks  Alcohol  Juices \_\_\_\_\_

Do you smoke? Yes  No  If yes, how much per day? \_\_\_\_\_

Do you have allergies to any food? If yes, explain: \_\_\_\_\_

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_