SKIN BOUTIQUE PATIENT INFORMATION

NAME			DATE
ADDRESS			
CITY		STATE	ZIP CODE
D.O.B.	Cell PH.		CELL PROVIDER
EMAIL			
HOW DID YOU HEAR ABOUT US			

MEDICAL HISTORY

ARE YOU CURRENTLY, OR HAVE YOU PREVIOUSLY EXPERIENCED ANY OF THE FOLLOWING

HEART CONDITION		CANCER		HEMOPHILIA		COLD SORES	
PACEMAKER		THROYID CONDITION		ASTHMA		AUTOIMMUNE	
HEADACHES		KIDNEY PROBLEMS		DIABETES		MUSCULOSKELETAL	
ANEMIA		HIGH BLOOD PRESSURE		HYPO/HYPER GLYCEMIA		HERPES SIMPLEX	
LOW BLOOD PRESSURE		ARTHRITIS		HEPATITIS		SCARRING/KELOIDS	

PLEASE LIST ALL ALLERGIES INCLUDING LATEX,FOODS,SEASONAL AND MEDICATIONS

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING

HAVE YOU EVER HAD ANY OF THE FOLLOWING

LASER RESURFACING		CHEMICAL PEELS		PERMANENT COSMETICS		DERMA FILLERS	
BOTOX		DERMASOUND		SCLEROTHERAPY			
DYSPORT		MICRODERMABRAISON		PLASTIC SURGERY			

IF HAVE HAD ANY OF THE ABOVE PLEASE EXPLAIN

ARE YOU PREGNANT OR PLANNING A PREGNANCY	YES	NO	

PLEASE INDICATE IF YOU HAVE EVER USED ANY OF THE FOLLOWING MEDICATIONS FOR SKIN TREATMENTS

ACCUTANE		RETIN A		FOSDEX		RENOVA	
CORTSONE		SULFER		GLYCOLIC ACID		CLINDAMYCIN	
STATICIN		DESQUAM X		SALICYLIC ACID		TAZORATENE	
BENZOYL PEROXIDE		ZERAC		LACTIC ACID		METROGEL	

WHAT CONDITION WAS BEING TREATED WITH THIS MEDICATION(S)

WHEN WAS THE LAST TIME YOU USED THESE MEDICATIONS

WHAT SKIN CARE PRODUCTS ARE CURRENTLY USING

ARE YOU USING A DAILY SUNSCREEN **TYPE** **SPF**

WHEN YOU LOOK IN THE MIRROR WHAT CONCERNS DO YOU HAVE

CELLULITE		WRINKLES		DRY SKIN		ROSACEA	
UNWANTED HAIR		ACNE		OILY SKIN		MELASMA	
CLOGGED PORES		ACNE SCARS		UNEVEN SKIN TONES		OTHERS	
FINE LINES		SPIDER VEINS		BROWN SPOTS			

WHAT IS YOU SKIN TYPE

ALWAYS BURN-NEVER TAN		RARLEY BURNS-TANS QUICKLY AND EASY	
USUALLY BURNS-TANS WITH DIFFICULTY		NATURALLY BROWN SKIN TANS QUICK AND EASY	
SOMETIMES BURNS - TANS TO A GOLDEN BROWN		NATURALLY BLACK SKIN	

DO YOU HAVE PHOTOSENSITIVE DISORDERS SUCH AS

VITILIGO		SCLERODERMA		HYPER/HYPO PIGMENTATION	
LUPUS		SUNBURN		OTHERS	

LIFESTYLE STRESS ANALYSIS

DO YOU COME IN CONTACT WITH ANY CHEMICALS AT WORK	YES / NO
DO YOU WORK AROUND EXCESSIVE HEAT OR COLD	
HOW OFTEN DO YOU EXERCISE	
AVERAGE HOURS OF SLEEP	
WHAT IS YOUR STRESS LEVEL	

PLEASE INDICATE ANY OF THE FOLLOWING THAT APPLY TO YOUR EATING HABITS

FAST FOOD		SALT YOUR FOOD		DAIRY PRODUCTS		PEANUT BUTTER	
BAKED BREAD		SEAFOOD		ETHNIC/SPICY FOODS		PEANUTS	

HOW MUCH WATER DO YOU DRINK PER DAY ? CAFFEINE ?

DO YOU SMOKE TABACCO PRODUCTS ? AVERAGE ALCOHOL CONSUMPTION PER WEEK

YES / NO HOW MUCH PER DAY

***I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR SERVICES RECEIVED**

SIGNATURE OF CLIIENT OR RESPONSIBLE PARTY _____

DATE _____ RELATIONSHIP TO CLIENT _____

EMERGENCY CONTACT _____ **PHONE #** _____