FACIAL QUESTIONNAIRE

TODAY'S DATE _____

NAME_____BIRTHDAY_____ /_____ /_____

ADDRESS_____CITY_____STATE___ ZIP_____

PHONE (___)____- _____ Appointment Reminder (CIRCLE ONE) CALL / TEXT / EMAIL

EMAIL_____

Emergency contact name & number:_____

How did you hear about us? AD / INT / REF NAME: _____

FOR PROFESSIONAL USE ONLY

Have you ever had a facial? YES/ NO Do you currently get regular facials? YES / NO How often?_____

Medical History:

Do you have any of the following medical conditions? YES/ NO If not listed below please list: _____

❑ Cancer	❑ Rosacea	❑ Arthritis
❑ Herpes	❑ Diabetes	❑ Hepatitis
❑ HIV / AIDS	❑ Keloid Scarring	❑ Blood Clotting Abnormalities
❑ Seizure Disorder	❑ Any Active Infection	❑ Skin Cancer
❑ Thyroid Imbalance	❑ High Blood Pressure	❑ Frequent Cold Sores
❑ Hormone Imbalance	❑ Skin Disease / Skin Lesions	❑ Autoimmune Disorder

Are you currently under the care of a physician or dermatologist? YES/ NO For what conditions?_____

Are you taking any medication? YES/ NO Please list: _____

_____

Topical medication? YES/ NO Please list: _____

_____

Have you had any cosmetic surgery? YES / NO Please list what and how long ago: _____

Have you had any surgeries where lymph nodes were removed? YES / NO IF yes, please list location: _____

Do you smoke? YES/ NO How much per day?_____

Are you currently pregnant or trying to become pregnant? YES/ NO _____

Have you ever used Accutane? YES/ NO If yes, when did you last use it:_____

Allergies:

Have you had an allergic reaction to any of the following?: (please check all that apply & describe the reaction you had)

❑ Food ❑ Latex ❑ Aspirin ❑ Lidocaine ❑ Hydrocortisone ❑ Hydroquinone or skin bleaching agents

Have you ever had a skin reaction to a fragrance or dislike any fragrance? YES / NO IF yes, please list: _____

Do you shower in the morning or evening? _____

Are you currently pregnant or trying to become pregnant? YES/ NO _____

Additional Background:
Have you used any of the following for hair removal in the last six weeks?
❑ Shaving ❑ Waxing ❑ Electrolysis ❑ Plucking/Tweezing ❑ Threading ❑ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? YES/ NO _____

Have you recently used any self-tanning lotions or similar treatments? YES/ NO _____

Do you form thick raised scars from cuts or burns? YES/ NO _____

Have you ever had Hyper-pigmentation (darkening of the skin) or Hypo-pigmentation (lightening of the skin) or marks after physical trauma? YES/ NO _____

Lifestyle:
Do you have any children? YES / NO If yes, how many?_____ Age range?_____

What is your occupation? _____

What are your hobbies/activities? _____

Current skin care routine. List brands and frequency.

Cleanser: Milky / Foamy_____Scrub: Fine / Coarse _____

Toner_____Moisturizer_____Sun Block _____

Serums_____Masks_____Eyes _____

What are your goals for your skin? (in other words, when you look in the mirror, what do you wish?)

_____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the Esthetician, Technician, Therapist, Doctor or Nurse of my current medical and health history and to update any current conditions. A current medical history is essential for the caregiver to execute the appropriate treatment procedures. (All information is strictly confidential)

CLIENT ACKNOWLEDGEMENT

_____	_____
Print name	Technician print
_____	_____
Client	Technician