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

FOR PROFESSIONAL USE – ANALYSIS

Completion: **CREAMY LIGHT LIGHT/MATTE MATTE BROWN BLACK**
Skin Analysis: **DRY COMBO OILY MATURE ACNE REACTIVE**
Dehydration: **MILD MODERATE SEVERE**
Thickness: **THIN MEDIUM THICK**
Do you get oily during the day? YES / NO Do you keloid? YES / NO

Did you react to products? YES/ NO List: ____________________

Did you have any allergies? YES / NO If yes, please list: ____________________

Line Chosen and Results ____________________

Date____________ Service____________________ Rebook Date ____________

Products Purchased ____________________

Notes: