Confidential Health & Skin Care History

Name:	Age:	Date of Birth:
Address:		
Email:		Cell:
Emergency Contact:		EC Phone:

Allergies

Check any applicable box(es) and write-in your reaction beside it

❑ Alpha Hydroxy Acid ❑ Certain foods ❑ Fragrance ❑ Medication ❑ Pollen
❑ Animals ❑ Cosmetics/Skin Care ❑ Iodine/Shellfish ❑ Milk ❑ Sunscreen
❑ Aspirin ❑ Essential Oils ❑ Latex ❑ Nuts ❑ No known allergies

Provide any allergies (and reactions) not listed above (or enter N/A)

Medications

Please list all medications, vitamins and supplements (OTC, RX, birth control, hormone replacement therapy)

Are you using or have you ever used Accutane or other RX for acne? ❑ No ❑ Yes (provide RX name & date(s) below)

Medical Conditions

Do you have any of the following health conditions:

❑ AIDS/HIV ❑ Extensive dental work ❑ Metal Implant(s)/IUD ❑ Skin Cancer
❑ Cancer ❑ Heart Problem ❑ Pacemaker ❑ Thrombosis
❑ Celiacs Disease ❑ Hepatitis ❑ Pregnant/Breastfeeding ❑ Thyroid condition
❑ Diabetes ❑ High/Low Blood Pressure ❑ Recent Surgeries ❑ N/A
❑ Epilepsy ❑ Lupus ❑ Stroke

Write in any health conditions not listed above (or enter N/A)

If you've been under the care of a physician, dermatologist or other within the past year please describe (or enter N/A)

Skin Care History

Please list any diagnosed skin conditions (or enter N/A)

General Considerations

Do you suffer from Cold Sores? ❑ Yes ❑ No If yes, do you take medication? ………………… ❑ Yes ❑ No
Do you form thick/raised scars from cuts or burns? ……………………………………………………… ❑ Yes ❑ No
Do you have pigmentation issues (lighter or darker) following skin trauma? ……………………… ❑ Yes ❑ No
Do you smoke? ……………………………………………………………………………………………… ❑ Yes ❑ No
Do you regularly use sunscreen or sunblock? ………………………………………………………… ❑ Yes ❑ No

Additional Considerations			How Recently?
Do you use tanning beds or self-tanner?	❑ Yes	❑ No	
Have you had facials before?	❑ Yes	❑ No	
Have you had any cosmetic treatments in the last year?	❑ Yes	❑ No	
Do you use a retinoid or Vitamin-A derivative? (Ex: RetinA, Renova, Adapalene, Differin, Retinol, Retinal, Tretinoin, RoC)	❑ Yes	❑ No	
Do you use an AHA or BHA? (Like Glycolic, Lactic, or Salicylic Acid)	❑ Yes	❑ No	
Do you use a Topical Vitamin-C?	❑ Yes	❑ No	
Do you get botox/fillers?	❑ Yes	❑ No	
Have you had a chemical peel?	❑ Yes	❑ No	
Have you had cosmetic surgery?	❑ Yes	❑ No	
Have you had laser resurfacing?	❑ Yes	❑ No	
Have you had any invasive procedures recently?	❑ Yes	❑ No	

What areas of concern do you have regarding your skin?

❑ Blackheads ❑ Dull/Dry Skin ❑ Rosacea ❑ Uneven Skin Tone
❑ Breakouts/Acne ❑ Enlarged Pores ❑ Sensitive skin ❑ Wrinkles/Fine Lines
❑ Broken Capillaries ❑ Excessive Oil/Shine ❑ Sun Damage ❑ Other
❑ Dehydrated ❑ Flaky Skin ❑ Sun/Liver/Brown Spots ❑ N/A

List your skincare products and/or text a group picture of them to 720-408-5396
(Include your cleansers, toners, serums, moisturizers, exfoliants, actives, SPF, everything you use daily and occasionally)

Morning Skincare Products	Evening Skincare Products

Is there any other information I should know?

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client/Parent/Guardian Signature

Date

Client/Parent/Guardian Name