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### CLIENT INFORMATION

TITLE <input type="checkbox"/> MR. <input type="checkbox"/> MISS <input type="checkbox"/> MRS. <input type="checkbox"/> DR.	NAME (LAST NAME FIRST)	AGE	DATE
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### SKINCARE QUESTIONNAIRE

ARE YOU CURRENTLY UNDER THE CARE OF A DERMATOLOGIST OR A PHYSICIAN FOR YOUR SKIN? (IF YES, EXPLAIN) \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_

HAVE YOU EVER SEEN A DERMATOLOGIST, OR OTHER PHYSICIAN FOR YOUR SKIN? (IF YES, EXPLAIN) \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_

WHAT SKIN CARE PRODUCTS DO YOU USE TO CLEANSER YOUR FACE? \_\_\_\_\_

WHAT SKIN CARE PRODUCTS DO YOU USE TO MOISTURIZE YOUR FACE? \_\_\_\_\_

HAVE YOU PREVIOUSLY HAD:

CHEMICAL PEEL    TYPE: \_\_\_\_\_    DATE: \_\_\_\_\_

LASER RESURFACING    TYPE/DEPTH: \_\_\_\_\_    DATE: \_\_\_\_\_

DERMABRASION    TYPE/DEPTH: \_\_\_\_\_    DATE: \_\_\_\_\_

MICRODERMABRASION    TYPE/DEPTH: \_\_\_\_\_    DATE: \_\_\_\_\_

AGGRESSIVE EXFOLIATION TREATMENT IN THE LAST 2 WEEKS? (EXPLAIN) \_\_\_\_\_

ARE YOU USING OR HAVE EVER USED:

ALPHA-HYDROXY ACIDS    DATE: \_\_\_\_\_     RETIN A OR RENOVA    DATE: \_\_\_\_\_

GLYCOLIC ACIDS    DATE: \_\_\_\_\_     RETINOL    DATE: \_\_\_\_\_

TOPICAL VITAMIN C    DATE: \_\_\_\_\_     HYDROQUINONE    DATE: \_\_\_\_\_

TOPICAL VITAMIN E    DATE: \_\_\_\_\_     KOJIC ACID    DATE: \_\_\_\_\_

KINERASE    DATE: \_\_\_\_\_     HYDROCORTISONE    DATE: \_\_\_\_\_

TOPICAL FLOUROURACIL PREPERATION (WHEN & WHAT AREA OF YOUR BODY): \_\_\_\_\_

OTHER (INCLUDE TOPICAL ANTIBIOTIC, OTC ACNE REMEDIES, ETC.): \_\_\_\_\_

ARE YOU TAKING ACCUTANE®?     YES     NO    IF YES, WHAT IS THE DOSAGE AND FREQUENCY: \_\_\_\_\_

HAVE YOU EVER TAKEN ACCUTANE®?     YES     NO    IF YES, LAST TAKEN ON: \_\_\_\_\_

#### HYPERSENSITIVITY AND SKIN FRAGILITY

HAVE YOU EVER HAD A SKIN ALLERGY OR SENSITIVITY (RASH, IRRITATION, PEELING, SWELLING, HIVES, ETC.) TO:

COSMETICS?     YES     NO    FABRRICS?     YES     NO    OTHER (LATEX, ETC.)? \_\_\_\_\_

DO YOU HAVE ANY KNOWN SYSTEMIC ALLERGIES TO ANYTHING? (IF YES, PLEASE LIST) \_\_\_\_\_

DO YOU "FLUSH" OR "APPEAR REDDENED" EASILY WHEN YOU EAT SPICY FOOD, DRINK ALCOHOL, GET ANGRY, GO IN THE SUN, ETC.?     YES     NO

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## SKINCARE QUESTIONNAIRE (PAGE TWO)

### FREE RADICAL EXPOSURE

DO YOU EXERCISE?  YES  NO      HOW OFTEN & TYPE: \_\_\_\_\_

DO YOU SMOKE?  YES  NO      HOW MUCH? \_\_\_\_\_

DO YOU CONSUME ALCOHOL?  YES  NO      HOW MUCH? \_\_\_\_\_

DO YOU HAVE A HEALTHY DIET?  YES  NO      LIST ANY DIETARY CONCERNS: \_\_\_\_\_

DO YOU FOLLOW A SPECIAL DIET?  YES  NO      EXPLAIN: \_\_\_\_\_

DO YOU DRINK 8 GLASSES OF WATER/DAY?  YES  NO      IF NOT HOW MUCH? \_\_\_\_\_

DO YOU TAKE VITAMINS?  YES  NO      TYPE OF VITAMINS: \_\_\_\_\_

ANTIOXIDANTS: \_\_\_\_\_      OTHERS: \_\_\_\_\_

### FOR WOMEN ONLY

DO YOU HAVE REGULAR PERIODS?  YES  NO      ARE YOU GOING THROUGH MENOPAUSE?  YES  NO

ARE YOU PREGNANT OR LACTATING?  YES  NO      HAVE YOU EVER BEEN PREGNANT?  YES  NO

ARE YOU TRYING TO BECOME PREGNANT?  YES  NO

DURING PREGNANCY DID YOU EVER EXPERIENCE HYPERPIGMENTATION OR A "PREGNANCY MASK"?  YES  NO

### PIGMENTATION (FITZPATRICK SCALE)

HOW DO YOU TAN?  BURN (I)       USUALLY BURN (II)       SOMETIMES BURN (III)

RARELY BURN (IV)       NEVER BURN - "BROWN" (V)       NEVER BURN - "BLACK" (VI)

PIGMENTATION:  HYPERPIGMENTATION       HYPOPIGMENTATION       BIRTHMARK

PREGNANCY MASK       OTHER: \_\_\_\_\_

WHAT IS YOUR NATIONALITY (HERITAGE)? \_\_\_\_\_

### VASCULARITY

TELANGIECTASIA / BROKEN CAPILLARIES:  NOSE AREA       CHEEK AREA       CHIN AREA

FOREHEAD       ENTIRE FACE

### ACNE

DO YOU HAVE ANY HISTORY OF ACNE OR PERIODIC BREAKOUT?  YES  NO

PIMPLES       WHITE HEADS       BLACKHEADS       ENLARGED PORES

ACNE SCARS       CYSTS       FLAKINESS

DO YOU ONLY EXPERIENCE A BREAKOUT AROUND YOUR MENSTRUAL CYCLE?  YES  NO

DO YOU ALWAYS HAVE A PIMPLE OR SOME TYPE OF BREAKOUT?  YES  NO

### FACIAL WRINKLES

DO YOU HAVE:  DEEP WRINKLES       FINE LINES       CROWS FEET

HAVE YOU BEEN TREATED WITH:  BOTOX/TX DATE: \_\_\_\_\_       COLLAGEN/TX DATE: \_\_\_\_\_       RESTYLANE/TX DATE: \_\_\_\_\_

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## SKINCARE QUESTIONNAIRE (PAGE THREE)

### SKIN TYPE

- DOES YOUR SKIN EVER FLAKE OR FEEL TIGHT AND DRY?  FREQUENTLY  OCCASIONALLY  VERY RARELY
- IS YOUR SKIN EVER SHINY A FEW HOURS AFTER CLEANSING?  FREQUENTLY  OCCASIONALLY  VERY RARELY
- HOW OFTEN DO YOU EXPERIENCE BLACKHEADS OR BLEMISHES?  FREQUENTLY  OCCASIONALLY  VERY RARELY
- HOW NOTICEABLE ARE YOUR PORES?  VERY  T-ZONE  NOT VERY

### ABILITY TO HEAL

- DOES YOUR SKIN APPEAR FRAGILE OR BURN EASILY?  YES  NO IF YES, EXPLAIN: \_\_\_\_\_
- DO YOU HAVE ANY PROBLEMS HEALING FROM A CUT OR BURN?  YES  NO IF YES, EXPLAIN: \_\_\_\_\_
- DO YOU EVER USE DEPILATORIES OR WAXES ON YOUR FACE?  YES  NO IF YES, EXPLAIN: \_\_\_\_\_
- HAVE YOU EVER HAD A "COLD SORE"?  YES  NO IF YES, EXPLAIN: \_\_\_\_\_

### SUN HISTORY & LIFESTYLE

- DO YOU WORK INSIDE?  YES  NO OCCUPATION: \_\_\_\_\_
- ARE YOUR HOBBIES DONE MOSTLY OUTSIDE?  YES  NO HOBBIES: \_\_\_\_\_
- IN THE PAST (INCLUDING CHILDHOOD) DID YOU LIVE IN A SUN BELT?  YES  NO WHERE DID YOU LIVE? \_\_\_\_\_
- IN THE PAST HAVE YOU NEGLECTED TO USE A SUNSCREEN?  YES  NO IF YES, EXPLAIN: \_\_\_\_\_
- DO YOU EVER USE TANNING BEDS?  YES  NO IF YES, WHEN? \_\_\_\_\_
- DO YOU CURRENTLY WEAR A SUN PROTECTION PRODUCT ALL DAY, EVERYDAY?  YES  NO
- ARE YOU WILLING TO WEAR A SUN PROTECTION PRODUCT ALL DAY, EVERYDAY?  YES  NO
- HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER?  YES  NO
- IF YES, WHO? \_\_\_\_\_ ANATOMICAL LOCATION: \_\_\_\_\_

### ENVIRONMENTAL POLLUTION

- ARE YOU EXPOSED TO:  WORKPLACE POLLUTION  POOR VENTILATION  SECONDARY SMOKE
- HOW DO YOU WANT TO IMPROVE YOUR SKIN? \_\_\_\_\_
- WHAT SPECIFIC AREAS DO YOU WANT TO TREAT?  NECK  FACE  CHEST  BACK  OTHER
- DO YOU WEAR CONTACT LENSES?  YES  NO

**SKIN CARE CONSENT:** I understand that although the products used for facial and body treatments at Minuet Day Spa is of the highest quality, it is possible that I may have an adverse reaction to a product or treatment. I understand that the risk of an adverse reaction is extremely low, however I accept the risk and consent to treatment by the therapists at Minuet Day Spa.

**CLIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**THERAPIST SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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