CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

This information will allow your professional skin care specialist to provide the optimum image products and services.

ACHIEVE Beautiful SKIN MEDI-SPA VIERA

PATIENT/CLIENT INFORMATION

Date _____

Name _____

Address _____

City/State/Zip _____

Home Phone _____

Work Phone _____

Cell _____

Email _____

Occupation _____

Referred by _____

MEDICAL INFORMATION

Date of birth _____ Age ____ Family physician _____

Do you smoke? _____ How often? _____ Living with smoker? _____

Have you been treated for: (Please check)

☐ Acne ☐ Depression ☐ Skin Disease ☐ Cancer

☐ High Blood Pressure ☐ Coldsores ☐ Diabetes

List of all allergies/allergic _____

List of all medications that you are currently taking _____

_____

Are you pregnant? ____ Trying to get pregnant? ____ Hormone therapy? ____

Are you prone to cold sores? _____

PERSONAL INFORMATION

Circle your current level of stress: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Circle your normal level of stress: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How many ounces of water do you drink daily? _____ Do you take supplements/vitamins? _____

Do you exercise? _____ If so, how often? _____ Your last sunburn? _____ Do you use tanning beds? _____

When you go out into the sun, do you (check one):

☐ ALWAYS BURN (I) ☐ USUALLY BURN (II) ☐ SOMETIMES BURN (III) ☐ RARELY BURN (IV) ☐ VERY RARELY BURN (V) ☐ NEVER BURN (VI)

Have you ever been under the treatment plan of a:

☐ Dermatologist ☐ Plastic Surgeon ☐ Esthetician Would you be interested in cosmetic surgery? _____

If yes, what procedure? _____

Are you concerned about skin condition on your body? (check all that apply)

☐ SUN SPOTS ☐ SKIN LAXITY ☐ DRY/ROUGH

What skin line are you currently using? _____

Do you use daily environmental protection product (sunblock)? _____ If not, why? _____

How do you feel about the overall quality of your skin: (Bad) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Fantastic)

Your skin type is? (Please check only one)

☐ NORMAL ☐ DRY/DEHYDRATED ☐ OILY ☐ ACNE/ACNE PRONE ☐ ROSACEA

In order of importance, please rank 1 (most important) to 5 (least important) improvement in the next 30 days:

_____ REDUCTION OF FINE LINES _____ REDUCTION OF BROWN SPOTS/SUN DAMAGE

_____ REDUCTION OF OIL/ACNE _____ ACNE SCARS DIMINISHED

_____ REDUCTION OF REDNESS

Problem areas (Please check all that apply)

☐ RIGHT FOREHEAD ☐ LEFT FOREHEAD

☐ LEFT EYE AREA ☐ RIGHT EYE AREA

☐ LEFT CHEEK ☐ RIGHT CHEEK

☐ CHIN ☐ NECK

PHOTOGRAPHIC CONSENT

_____ I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after procedures. The photographs will be taken by one of the staff from Achieve Beautiful Skin.

_____ I hereby give my consent for Achieve Beautiful Skin to use the photographs the following circumstances:

☐ ALL MEDIA ☐ WEBSITE ☐ PHOTO ALBUM

Signature _____ **Date** _____