

**Skincare History and Questionnaire**

**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Have you seen a physician, dermatologist or other medical professional in the past year? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, what was the reason for your visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any medications (over the counter, prescription, vitamins, prescriptive skincare) you take regularly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any of these health conditions in the past or currently? (Circle)**

Arthritis Headaches (Chronic) Metal Implants Lupus

Active Infection Heart Attack Pace Maker/Electrical Implant

Anemia Heart Transplant Phlebitis/Blood Clots

Asthma High/Low Blood Pressure Poor Circulation

Autoimmune Disorder Hepatitis Seizure/Epilepsy

Cancer HIV/AIDS Spinal Injury

Claustrophobia  Hormone Imbalance Stroke

Diabetes Hysterectomy Skin Disease

Eczema Immune Disorders Systemic Disease

Fainting Irregular Pulse Thyroid Condition

Herpes/Cold Sores Keloid Scarring Varicose Veins

Do you have a tendency to scar? Yes\_\_\_\_\_ No\_\_\_\_\_\_

Are you on hormone replacement therapy? Yes\_\_\_\_No\_\_\_\_

Are you currently taking birth control? Yes\_\_\_\_No\_\_\_\_

Are you pregnant or nursing? Yes\_\_\_\_No\_\_\_\_

**Allergies**

Circle any item you have had an allergic reaction to:

Aspirin or Salicylates Citrus Fish, Marine, Iodine Nuts

Apples Grapes Latex Milk

Ingredients in skincare products:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any other known allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Skincare History**

Are you currently undergoing any skin treatments? Yes\_\_\_\_No\_\_\_\_

If yes, what type of treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please circle if you have used any of these ingredients in the past 30 days:**

Benzoyl Peroxide Tretinoin (Retina A, Retin A-Micro, Renova, Avita) Resorcinol

Glycolic Acid Lactic Acid Metrogel

Triluma Salicylic Acid Tazorac

Azelaic Acid (Finacea, Azelex) Acutane Adepalene(Differin)

**Please circle any treatment you have had in the past 14 days:**

Facial Cosmetic Surgery Collagen Injections Laser Resurfacing Chemical Peels

Botox/Filler Microdermabrasion Light Treatments

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle if you are presently experiencing or have experienced any of the following:**

Skin Cancer Acne Treatment reactions

Dermatitis Rosacea Hyperpigmentation

Keloid Scarring Broken Capillaries Hypopigmentation

**Home Care**

What skincare products are you currently using at home?

Cleanser\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vitamin C\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exfoliants/Scrubs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Moisturizer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Masks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sunscreens\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty Products\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use sunscreen? Yes\_\_\_\_ No\_\_\_\_ If yes, what SPF? \_\_\_\_\_\_

How often are you outdoor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your skin respond to sun exposure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your skin conditions? (Circle)

Acne/Breakouts Facial Scarring Hyperpigmentation (Freckles/Sun Spots)

Enlarged Pores Fine Lines and Wrinkles Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dermaplaning Consent (Complete if considering treatment.)**

Dermaplaning is a manual, non-invasice, skin resurfacing procedure that uses a special tool to remove the top layer of dead skin cells, as well as, velus hair or peach fuzz. It helps to improve texture, tone and the appearance of fine lines.

**Contradictions**

If you are currently experiencing any of the following conditions, we will need to reschedule your appointment.

Sunburned or irritated skin Open Skin Lesions Dermatitis

Accutane within the last 12 months Active Cold Sores Uncontrolled Diabetes

Current inflamed acne lesions Skin Cancer

There is a possible risk of nicking the skin as a potential complication of the treatment. Initial: \_\_\_\_\_\_\_\_\_\_\_

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* I attest that I am above the age of 18: \_\_\_\_\_\_(initial)
* I authorize About Face of New Orleans to take pictures of my progress: \_\_\_\_\_(initial)
* I attest that I have answered this questionnaire truthfully: \_\_\_\_\_\_(initial)

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Esthetician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_