SkinZoneRx
skin care with results.

Client Medical History

Date: _____ Name: _____

Date of Birth: _____ Address: _____City_____

State_____ Zip_____HomePhone:_____ Cell Phone: _____

E-mail address: _____

Single / Married Referred by: _____

Occupation: _____ Emergency Contact: _____

Does your job require that you work outdoors? ○No ○Yes

What procedures are you interested in? Check all that apply

○Laser Hair Removal ○IPL brown spots or redness ○Microdermabrasion ○Facial ○Microneedling

○Botox ○Dermal filler ○Tattoo Removal ○Acne ○Skin Resurfacing ○Lines & Wrinkles

○Skin Tightening ○ Lamprobe. ○ Permanent Cosmetics ○HydraFacial ○Chemical Peels ○ Cryocorrect

○IV Therapy ○Weight Loss ○Sexual Health

What would you like to achieve from your treatments?

_____

List all medications and supplements:_____

_____

_____

List any medication or food allergies_____

Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain) If yes, please explain:

_____

○Cosmetics ○Medicine ○Food ○Animals ○Sunscreens ○Iodine ○Pollen ○AHA

○Fragrance ○Salicylic Acid ○Shellfish ○Latex ○Drugs ○Sun ○Numbing agents

Client Initial_____

Have you ever taken Accutane? Y/N If yes, when did you stop?_____

Please check any condition that you currently have or have had in the past: ○Heart Problem ○Diabetic ○HIV ○Lupus ○Hepatitis ○Auto Immune Disease ○Bruise Easily ○Poor Wound Healing ○Claustrophobic ○Asthma ○Eczema ○Psoriasis ○Vitiligo ○Keloid Scar ○Pacemaker ○Metal Implant ○Seizure ○Epilepsy ○Anxiety ○Depression ○Hyper/Hypo Thyroid ○PCOS ○Excessive Hair Growth ○Excessive Hair Loss ○Permanent Makeup ○Tattoo ○MS ○ALS ○ Bell's Palsy ○Cold Sores ○Shingles ○High Blood Pressure ○Varicose Veins

Past surgical history (ie, metal implants, stents, pacemaker)_____

_____

Your Skin Care

1) Have you ever had a facial treatment before? ○No ○Yes, when? _____ _____

2) Which of the following best describes your skin when exposed to the sun for 30 minutes & no SPF:

○ Always burns easily, never tans with very pale skin tone
○ Always burns, tans with a hint of color with very pale skin tone
○ Burns initially, tans gradually with light skin tone
○ Can burn and can tan with olive/gold skin tone
○ Rarely burns with brown skin tone
○ Rarely burns with very deeply pigmented skin tone

Your ethnicity: _____

3) Do you have any special skin problems or concerns pertaining to your face or body? ○Yes ○No

If yes, please specify: _____

4) Have you ever had chemical peels, laser or microdermabrasion? ○No ○Yes

In the last month? ○No ○Yes If yes, please describe: _____

5) Do you use Retin-A, Renova, Hydroquinone, Hydroxyl Acid or Retinol/vitamin A derivative products?

○No ○Yes

If yes, please describe:
_____

6) Have you used any of the above products in the last 3 months? ○No ○Yes

Client Initial_____

7) Have you used an acne medication? ONo OYes, when? _____

What type? _____

8) What skin care products are you currently using? (List brand)

_____

9) Have you recently used any self-tanning lotions, creams or treatments ONo OYes

Please specify: _____

10) Have you used any of the following hair removal methods in the past 4 weeks? ONo OYes

If yes, where on your body?_____

Please choose all that apply:

OShaving OWaxing OElectrolysis OPlucking OTweezing OThreading ODepilatories OLaser

11) What areas of concern do you have regarding your skin? Check all that apply

OBreakouts/acne OBlackheads/whiteheads OExcessive oil/shine ORosacea ODehydrated skin

OBroken capillaries ORedness/ruddiness OSun spot/liver spot/brown spot Opuffiness Odark circles

OUneven skin tone OSun damage OWrinkles/fine lines ODull/dry skin OFlaky skin

Other _____

12) What SPF do you use on your face? _____ How often/when? _____

13) What SPF do you use on your body? _____ How often/when? _____

14) In the last 2 weeks, have you had any tanning bed or sun exposure?

Did you tan or burn? ONo OYes

Please specify: _____

15) In the last 2 weeks, have you had injections such as Botox™, Restylane™ or Collagen? ONo OYes

Please specify: _____

Client Initial_____

Female Clients Only:

16) Are you taking oral contraceptives? ○No ○Yes

Please specify: _____

17) Any recent changes to or from your contraceptive treatment? ○No ○Yes If so, what and when: _____

18) Are you pregnant or trying to become pregnant? ○No ○Yes

19) Are you lactating? ○No ○Yes

20) Any menopause problems? ○No ○Yes

Please specify: _____

21) Are you undergoing any hormone replacement therapy? ○No ○Yes

Please specify: _____

Male Clients Only:

22) What is your current shaving system? ○Wet shave ○Electric

23) Do you experience irritation from shaving? ○No ○Yes Ingrown hairs? ○No ○Yes

Future Appointments/Contact:

May we call home, work or cell phone number to confirm future appointments?

○No ○Yes Preferred method of contact:

May we contact you via email to confirm appointments and send our promotions? ○No ○Yes

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 complications from your treatment that may be irreversible. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

Client Signature:

_____

Date: _____

Medical Director Reviewed

_____Date_____

Client Initial_____