

**PATIENT/CLIENT INFORMATION**

**MEDICAL INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_

CELL \_\_\_\_\_

EMAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_ LIVING WITH A SMOKER? \_\_\_\_\_

HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)

- ACNE    DEPRESSION    SKIN DISEASE    HIGH BLOOD PRESSURE  
 COLDSORES    DIABETES    CANCER

LIST OF ALL ALLERGIES/ALLERGIC \_\_\_\_\_

LIST 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 (CIRCLE 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 CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)

- SUN SPOTS    SKIN LAXITY    DRY / ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING? \_\_\_\_\_

DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? \_\_\_\_\_ IF NOT, WHY? \_\_\_\_\_

CIRCLE HOW 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:

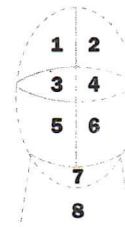
\_\_\_\_ REDUCTION OF FINE LINES

\_\_\_\_ ACNE SCARS DIMINISHED

\_\_\_\_ REDUCTION OF BROWN SPOTS/SUN DAMAGE

\_\_\_\_ REDUCTION OF REDNESS

\_\_\_\_ REDUCTION OF OIL/ACNE



1 RIGHT FOREHEAD

5 LEFT CHEEK

2 LEFT FOREHEAD

6 RIGHT CHEEK

3 LEFT EYE AREA

7 CHIN

4 RIGHT EYE AREA

8 NECK

**TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)**

PROFESSIONAL TREATMENT RECOMMENDATION

- CHEMICAL PEEL    MICRODERMABRASION    DUAL PEEL    ORMEDIC/ORGANIC PASSION PEEL    TCA ORANGE PEEL

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.

THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_