Skin Consultation Form

Please answer the following questions thoroughly and completely as this provides a better understanding of your general health, lifestyle, and skin care concerns, thereby enabling the best treatment and home care recommendations.

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____

Date of birth (month and day): _____ **Let us thank the person who referred you:** _____

____ **Yes, I want to receive emails from Pureskin Aesthetic Salon, including event details, the newsletter, and promotions.**

Skin Care History

If there was something you could change or improve about your skin, what would it be?

_____

_____

What else? Please circle all that apply.

Discoloration (Brown Spots or Melasma)	Acne Scarring	Uneven Texture
Fine Lines & Wrinkles	Enlarged Pores	Sun Damage
Dry, Flaky Skin	Rosacea	Loss of Facial Contours
Oily Skin	Dilated Capillaries	Lax or Sagging Skin
Acne/Breakouts	Redness (Reactive Skin)	Dark Under-Eye Circles

What type of skin do you think you have?

Dry: _____ Normal: _____ Combination: _____ Oily: _____

If oily, are you oily throughout the cheek area? Yes: _____ No: _____

Do you have a history of acne? Yes: _____ No: _____

If yes, are you using or have you ever used any medications for acne? Yes: _____ No: _____

Name of medication: _____

Do you sunbathe or participate in outdoor activities? Yes: _____ No: _____

Have you ever had a reaction to any skin care product or cosmetic? Yes: _____ No: _____

If yes, please list: _____

What skin care do you currently use?

Morning	**Evening**
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

Please circle any medications you are currently using or have used:

Retinol	Benzoyl Peroxide (BPO)	Adapalene (Differin®)
Glycolic Acid	Hydroquinone	Azelaic Acid (Azelex®, Finacea®)
Salicylic Acid	Tretinoin	Isotretinoin (Accutane®)
Citric Acid	Topical Antibiotics	
Resorcinol	Topical Steroids	

Have you ever, or are you currently receiving skin treatments? Yes: _____ No: _____

Have you had any of the following? (Circle all that apply):

Chemical Peels	Permanent Cosmetics	Extractions
Laser Resurfacing	Light Treatments	Electrolysis
Facial Cosmetic Surgery	Microderm Abrasion	Laser Hair Removal
Facial Injectibles	Dermaplanning	Waxing

If yes, when was your last treatment? _____

Were there any complications? Yes: _____ No: _____

If yes, please explain: _____

General Health

Are you currently under the care of a physician? _____

If yes, please discuss contraindications of any pre-existing medical conditions with your physician.

Are you currently taking any medications? Yes: _____ No: _____

If yes, please list here: _____

Female Clients

Are you on hormone-replacement therapy? Yes: _____ No: _____

Are you on birth control pills? Yes: _____ No: _____

Are you pregnant or breastfeeding? Yes: _____ No: _____

Please circle all of the following conditions you have, or have had, in the treatment area:

Dermatitis	Cold Sores or Fever Blisters
Eczema	Actinic Keratosis
Psoriasis	Keloid Scarring
Open Sores or Lesions	

Are you allergic to aspirin? Yes: _____ No: _____

If you have any known allergies, please list them: _____

Is there anything else that should be known before starting your treatment?: _____

_____

_____

_____ _____

Signature **Date**