Skin Care Intake Form

1. Within the last year, have you been under a dermatologist's or other physician's care?

2. List any medications, supplements, vitamins, diuretics, slimming pills, Isotretinoin, etc, that you take regularly.

3. Do you smoke?

4. Do you have metal implants, a pacemaker, or body piercings?

5. Do you have any allergies? If yes, please specify.

6. Do you sunbathe or use tanning beds?

7. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks)

8. What are your specific concerns/challenges with your skin?

9. What skin care products are you currently using? Circle all that apply.
   Face: Soap Cleanser Toner Moisturizer Masque Exfoliator Eye Products
   Body: Soap Shower Gel Scrubs Oil Body Moisturizer Depilatory Products Self Tanners

10. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? In the last month?

11. Are you currently using any products that contain the following ingredients:
    Glycolic Acid Lactic Acid any exfoliating scrubs Any Hydroxy Acid Product Vitamin A Derivatives

12. Do you ever experience any of these conditions on your skin: Flakiness Tightness Obvious Dryness

13. What SPF sunscreen do you use on your face? On your body?

14. Do you burn easily in moderate sunlight?

15. Do you have a tendency to redness?

16. Do you suffer from sinus problems?

17. Do you ever experience burning, itching, or stinging sensations on your skin?

18. **Female Clients Only**

19. Are you taking oral contraception?

20. Are you pregnant or trying to become pregnant?

21. Are you lactating?

22. Are you currently having or due for your menstrual period?

23. Male Clients Only

24. Do you have any shaving challenges? If yes please specify.

25. **Questions to discuss every visit**

26. Have you started any new medication since your last visit?