

Skin Analysis & Anti-Aging Cosmetic Consultations Questionnaire

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Married \_\_\_ Yes \_\_\_ No

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your job require working outdoors? \_\_\_ Yes \_\_\_ No

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to achieve from your skin care & treatment program?

On a scale of 1 to 10, 10 being ecstatic, how happy are you with the current condition of your skin? \_\_\_\_\_\_\_\_\_

What is your current skin care regimen?

Soap\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mask\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exfoliator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scrubs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cleanser\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Moisturizer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sunscreen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Night Moisturizer \_\_\_\_\_\_\_\_\_\_\_\_\_

Fade Cream \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mechanical Cleaner \_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any special skin problems or concerns pertaining to your face? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you form Keloids? \_\_\_ Yes \_\_\_ No
Do you get fever blisters? \_\_\_ Yes \_\_\_ No

Have you ever had chemical peels, microdermabrasion, microneedling, or lasers? \_\_\_ Yes \_\_\_ No In the last month? \_\_\_ Yes \_\_\_ No

Have you used any of the following hair removal methods in the past six weeks? \_\_\_ Yes \_\_\_ No Circle all that apply……………

Shaving Waxing Electrolysis Plucking Tweezing Threading Depilatories

Do you use Retin-A, Renova, Tazorac, Differin, Epi-Duo, Glycolic Acid or other retinoid or retinol products? \_\_\_ Yes \_\_\_ No

Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used any of these products in the last 3 months? \_\_\_ Yes \_\_\_No

Have you used any acne medications? Which drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an allergic reaction to any of the following?

\_\_\_ Latex \_\_\_Fragrance \_\_\_Drugs \_\_\_Food \_\_\_Skin Products \_\_\_Other

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Clients Only:**

Are you taking oral contraceptives? \_\_\_ Yes \_\_\_ No Specify\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or trying to become pregnant? \_\_\_ Yes \_\_\_ No

Are you nursing? \_\_\_ Yes \_\_\_ No

Any menopause problems? \_\_\_ Yes \_\_\_ No Specify \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you undergoing any hormone replacement therapy? \_\_\_ Yes \_\_\_ No

 Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have unwanted facial hair growth or hair bumps? \_\_\_ Yes \_\_\_ No

 Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Male Clients Only:**

What is your current shaving system?

\_\_\_ Wet Shave \_\_\_ Electric Shaver \_\_\_ Clippers \_\_\_ Straight Razor
\_\_\_ Depilatory Creams or Powders \_\_\_ Wear a Beard

Do you experience irritation from shaving? \_\_\_ Yes \_\_\_ No

Ingrown Hairs \_\_\_ Yes \_\_\_ No

Please use this space to provide any additional information you would like for us to know \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Areas of Concern Do You Have Regarding Your Skin?

\_\_\_ Acne/Breakouts

\_\_\_ Acne Scars

\_\_\_ Blackheads/Whiteheads

\_\_\_ Excessive Oil/Shine

\_\_\_ Rosacea

\_\_\_ Broken Capillaries

\_\_\_ Redness/Rudiness

\_\_\_ Sun Spot/liver spot/brown spot

\_\_\_ Uneven Skin Tone

\_\_\_ Sun Damage

\_\_\_ Aging Skin

\_\_\_ Wrinkles/Fine Lines

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes**

\_\_\_ Wrinkles

\_\_\_ Puffiness

\_\_\_ Dark Circles

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_