Esthetics Skillbook

Confidential Patient Information

Date _____

Name _____ Date of Birth _____

Address _____

_____

Email Address _____

Daytime Phone _____ Work Phone _____ Cell Phone _____

Your Occupation _____

Dermatologist _____ Phone _____ / Physician _____ Phone _____

Emergency Contact _____ Phone _____

Referred by Friend ❑ Newspaper Advertisement ❑ Mailer or Insert ❑ Other _____

Yes ❑ No ❑ Is this your first facial? Yes ❑ No ❑ body treatment? Yes ❑ No ❑ massage?

If not, when was your last facial _____ body treatment _____ massage _____?

What is the reason for your visit today? _____

What special concerns do you have? _____

Yes ❑ No ❑ Are you currently under a physician's care for any skin conditions?

If so, what condition specifically and for how long: _____

Yes ❑ No ❑ Have you had a recent operation? If so, please describe _____

Yes ❑ No ❑ Were any medications prescribed?

Yes ❑ No ❑ Are you still on medication?

Yes ❑ No ❑ If so, what kind? _____ What is the dosage? _____

Yes ❑ No ❑ Is the area of the operation still sensitive to different temperatures or amounts of pressure?

What is the date of your last gynecological visit? _____ Pap smear? Yes ❑ No ❑

Breast exam? Yes ❑ No ❑ Mammogram? Yes ❑ No ❑ Menstrual cycle? Yes ❑ No ❑

Yes ❑ No ❑ Are you pregnant? If so, how far along? _____ Are you (will you be) nursing? Yes ❑ No ❑

Yes ❑ No ❑ Are you taking birth control? If so, what kind and for how long? _____

Yes ❑ No ❑ Have you seen any changes in your skin since you started using it?

If you have, what changes have you seen? _____

Yes ❑ No ❑ Are you on hormone replacement therapy?

If so how has your skin adjusted to it? _____

Yes ❑ No ❑ Have you had any problems with moisture loss/becoming drier in any areas?

Date of last dental exam ___/___/___

Yes ❑ No ❑ Were dental x-rays required?

Yes ❑ No ❑ Do you wear contact lenses?

Yes ❑ No ❑ Do you smoke? If so, how much and how often? _____

Do you normally smoke inside ❑ or outside ❑?

If you DO NOT smoke, are you around smoke while at home ❑ or in the workplace ❑?

If yes, how often are you around it? _____

Yes ❑ No ❑ Do you have difficulty managing stress?

Yes ❑ No ❑ Do you or have you had cancer?

If so, what type and where? _____

When was it discovered? _____

When was your last treatment? _____

What kind of treatment was it? _____

Yes ❑ No ❑ Has anyone in your family ever been diagnosed with cancer?

If so, how are they related to you? _____

Are you using (or used): Azelex ❑ Differin ❑ Renova ❑ Retin-A ❑ Tazarac ❑ Accutane ❑

Glycolic or Alphahydroxy Acids ❑ If so, how long? _____

What are you using it for? _____

Yes ❑ No ❑ Have you noticed a difference? If so, what? _____

Yes ❑ No ❑ Do you have any concerns with the use of this product? If so, what? _____

Yes ❑ No ❑ Do you have acne or experience frequent blemishes? How frequently: _____

Yes ❑ No ❑ Do you have any allergies? If so please list: _____

Yes ❑ No ❑ Are you taking allergy medications? If so please list: _____

Yes ❑ No ❑ Are you taking any medications not listed above? If so, please list: _____

What products do you presently use for face & body? Soap ❑ Cleanser ❑ Toner ❑ Scrub ❑

Moisturizer ❑ Mask ❑ Sunscreen ❑ Other: _____

What brand/line are these products? _____

How do these products seem to be working for you? _____

How often do you use these products? _____

What is the SPF in any sunscreens you may be using? _____

Do you take: Fish Oil ❑ Flax Seed ❑ Multivitamin ❑ Energy-Enhancing Supplement ❑

If so, what kind and how often? _____

Yes ❑ No ❑ Have you noticed a difference in anything? _____

Daily water consumption? None ❑ 1-4 glasses ❑ 5-8 glasses ❑ More than 8 ❑

Daily caffeine consumption? None ❑ 1-2 cups of coffee ❑ 1-2 cans of soda ❑ ...or more ❑

How often do you exercise? Never ❑ daily ❑ 2-3 times a week ❑ weekends only ❑

Please check if you are affected by or are currently experiencing any of the following:

Anemia ❑	Cortisone treatments ❑	High blood pressure ❑	Respiratory disease ❑
Arthritis ❑	Diabetes ❑	Immune Disorders ❑	Shortness of breath ❑
Asthma ❑	DVT or Phlebitis ❑	Jaw pain ❑	Sinus problems ❑
Back problems ❑	Eating Disorder ❑	Kidney disease ❑	Skin diseases ❑
Bleeding gums ❑	Eczema ❑	Liver disease ❑	Skin rash ❑
Blood disorders ❑	Epilepsy ❑	Lupus ❑	Swelling of feet or ankles ❑
Broken Bones ❑	Fever blisters ❑	Metal pins or plates ❑	Thyroid problems:
Bruise Easily ❑	Headaches ❑	Nervous problems ❑	Hyperthyroid ❑
Cardiac problems ❑	Hemophilia ❑	Numbness ❑	Hypothyroid ❑
Chemotherapy ❑	Hepatitis ❑	Pacemaker ❑	Ulcer ❑
Circulatory problems ❑	Herpes ❑	Psychological problems ❑	Urinary/kidney problems ❑
Claustrophobia ❑	HIV/AIDS ❑	Radiation treatments ❑	Varicose Veins ❑

Please explain any of the above, including treatments or any significant others not mentioned: _____

_____

_____

_____

_____

_____

_____

_____

Please check any known allergies:

Aspirin ❑ Barbiturates ❑ Codeine ❑ Iodine ❑ Local anesthesia ❑ Penicillin ❑ Sulfur ❑ Other ❑ _____

I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I further understand that the information herein is to aid the esthetician in giving the most appropriate and safe treatment available and remains confidential.

Client Signature _____ Date _____

Consent to administer treatment for Minor/Dependent: Parent/Guardian _____ Date _____

Esthetician: _____ Makeup Artist: _____ Massage Therapist: _____

Hair Removal Technician: _____ Client comfort level: Sensitive ❑ Hot ❑ Cold ❑

©2002 L. Saphonia Gee. All Rights Reserved