SKINCARE & DERMAPLANING INTAKE FORM

Name: ____ DOB: ___________________________ Date _______________

Email: ____ Cell #: ___________________________

TELL ME ABOUT YOUR SKIN *FOR AN EFFECTIVE, PERSONALIZED TREATMENT, PLEASE BE AS ACCURATE AS POSSIBLE

Skin Type:

☐ Normal ☐ Combination ☐ Oily ☐ Dry ☐ Mature ☐ Breakouts ☐ Acne ☐ Sensitive ☐ Rosacea

What skin conditions would you like to improve?

☐ Acne/Acne Scarring ☐ Pustules (Inflamed) ☐ Enlarged Pores ☐ Blackheads/Whiteheads ☐ Age Spots

☐ Visible Capillaries ☐ Sun Damage ☐ Fine Lines/Wrinkles ☐ Hyper-pigmentation (brown spots)

☐ Other ____________________

Have you ever been prescribed Accutane™?

☐ Yes ☐ No Last Date Used ____________________

Please check if using any of the following:

☐ Hydroquinone ☐ Glycolic /Alpha Hydroxy Acid ☐ Retinoid (Vitamin A derivatives: Retin-A, Renova, Differin, Tazorac, Tretinon)

☐ Other ____________________

Are you sensitive to any skin care ingredients or cosmetics?

☐ Yes ☐ No Last Date Used ____________________

Have you recently received any of the following?

☐ Face Treatment Date ____________________ ☐ Microneedling Date ____________________

☐ Chemical Peel Date ____________________ ☐ Ultherapy Date ____________________

☐ Laser/IPL Date ____________________

Have you ever had any of the following?

☐ Botox Injections Date ____________________ ☐ Restylane Injections Date ____________________

☐ Collegen Injections Date ____________________ ☐ Laser Resurfacing Date ____________________

☐ Rhytidectomy (Face Lift) Date ____________________ ☐ Rhinoplasty (Nose) Date ____________________

☐ Blepharoplasty (Eye lift) Date ____________________ ☐ Skin Cancer Date ____________________

☐ Other Date ____________________

GENERAL HEALTH

Do you suffer from allergies? (Sulfa, food, iodine, medications, hay fever, latex)

☐ Yes ☐ No If yes, please specify: ____

Are you currently taking any medications, herbs or vitamins? ☐ Yes ☐ No If yes, please specify: ______________________

How many glasses of water do you consume daily? ____

When exposed to sun, do you: ☐ Burn Easily ☐ Tan Easily ☐ Never Burn ☐ Never Tan

Are you under a physician's care for any reason? ____

What's your general health? ____

For women only: ☐ HRT ☐ Menopause ☐ Pregnant ☐ Birth Control Pills

Do any of the following apply to you? ☐ Smoker ☐ Wear Contacts

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Anti-Aging Centers
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