



Skin Care Consent Form

Name: _____

Email _____

Have you had facial surgery / laser / chemical or Herbal peel? Yes No

Describe: _____

How long ago? _____

Are you planning to have facial surgery / laser /chemical or Herbal peel? Yes No

When? _____ What type? _____

Are you pregnant, lactating or trying to get pregnant? Yes No

Do you smoke? Yes No

Do you develop cold sores/fever blisters? Yes No

When was your last outbreak? _____

Are you taking any medication at this time? Yes No

(Antibiotics may increase sensitivity) List: _____

Have you ever used Accutane? Yes No

When? _____

Are you currently using Retinoids (Retin-A, Renova, Differin, Tazorac, Avita)? Yes No

What strength? _____ For how long? _____

Any irritation or sensitivity? Yes No

Are you in the habit of sun bathing or going to tanning booths? Yes No

What temperature water do you use when cleansing skin? Hot Cold

Do you have a tendency to have a red face, telangectasia/broken capillaries? Yes No

Do you experience irritation from shaving? Yes No

Do you get ingrown hairs? Yes No

Do you have allergies? Please list

Describe your skin. Check all that apply.

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> normal | <input type="checkbox"/> normal/dry | <input type="checkbox"/> oily | <input type="checkbox"/> t-zone/combination |
| <input type="checkbox"/> melasma | <input type="checkbox"/> sun damaged | <input type="checkbox"/> uneven (brown spots) | <input type="checkbox"/> uneven (red spots) |
| <input type="checkbox"/> loose (jowl) | <input type="checkbox"/> loose (neck) | <input type="checkbox"/> loose (eye areas) | <input type="checkbox"/> lines/wrinkles |
| <input type="checkbox"/> active acne | <input type="checkbox"/> adolescent acne | <input type="checkbox"/> acne scars | <input type="checkbox"/> cystic acne |
| <input type="checkbox"/> sallow | <input type="checkbox"/> rosacea | | <input type="checkbox"/> clogged pores |

Which best describes your skin type?

- Type 1 White Always burns, never tans
 Type 2 White Usually burn, difficult to tan
 Type 3 White Sometimes mild burn, average tan
 Type 4 Brown Rarely burn, tan with ease
 Type 5 Dark Brown Rarely burn, tan very easily



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Type 6 Black Very rarely burn, tan very easily

What are the skin care improvements you would like to see in your skin? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> help diminish fine lines/wrinkles | <input type="checkbox"/> lighten/soften acne scars |
| <input type="checkbox"/> smooth skin texture | <input type="checkbox"/> restore elasticity |
| <input type="checkbox"/> diminish excess flakiness | <input type="checkbox"/> hydrate skin |
| <input type="checkbox"/> lighten discolored areas | <input type="checkbox"/> decrease oiliness |
| <input type="checkbox"/> minimize pore size | <input type="checkbox"/> clear up breakouts |
| <input type="checkbox"/> help clear up blackheads/whiteheads | |

When was your last facial? What type of facial treatment did you receive?

List any concerns or questions you have that have not been listed:

Signature _____

Date _____