CLIENT FILE-SKIN DIAGNOSIS

NAME: DATE:

ADDRESS:

CITY: PROVINCE: POSTAL CODE:

HOME PHONE: MOBILE PHONE: WORK PHONE:

D.O.B: OCCUPATION: REFERED BY:

EMAIL:

HEALTH HISTORY

WHAT WAS YOUR LAST AESTHETIC TREATMENT? WHEN?

ARE YOU PRESENTLY UNDER THE CARE OF A DERMATOLOGIST? YES NO

FOR WHAT CONDITIONS?

WHAT SURGERIES HAVE YOU UNDERGONE IN THE PAST 6 MONTHS?

WHAT COSMETIC SURGERY HAVE YOU HAD?

WHAT VITAMINS/HERBAL REMEDIES ARE YOU TAKING?

WHAT MEDICATIONS ARE YOU TAKING?(INCL BCP)

HAVE YOU TAKING THE FOLLOWING MEDICATIONS IN THE PAST 24HOURS?

ACUTANE RETINAL RETIN A RENOVA DIFFERIN

DO YOU WEAR CONTACT LENSES? YES NO

DO YOU HAVE A PACE MAKER? YES NO

DO YOU HAVE METAL INCLUSION? YES NO

DO YOU SMOKE? YES NO

DO YOU HAVE ANY SENSITIVITIES TO FRAGRANCES/AROMAS? YES NO

ARE YOU ALLERGIC TO THE FOLLOWING? SULPHUR COLLAGEN CITRUS

NUTS OTHER ALLERGIES?

DO YOU TAN? YES NO BED/SUN? YES NO FREQUENCY?

WHAT SPF PROTECTION DO YOU USE?

WHAT IS YOUR STRESS LEVEL? LOW MEDIUM HIGH

IS YOUR WEIGHT GENERALLY STABLE? (RECENT GAIN/LOSS)

WHAT IS YOUR EXCERSISE ROUTINE LIKE?

HOW OFTEN DO YOU CONSUME THE FOLLOWING? (**D**AILY, **W**EEKLY, **M**ONTHLY)

SMOKED FOODS___ CAFFEINE___ ALCOHOL__ WATER____ SWEETS____

SALT_____ DAIRY____ PROTEIN_____ MEAT____ FRIED FOOD__ SOFT DRINK_

FEMALE CLIENTS ONLY			**MALE CLIENTS ONLY**		
ARE YOU PREGNANT OR TRYING?	YES	NO	HAVE YOU EXPERIENCED		
TO BECOME PREGNANT?	YES	NO	IRRITATION FROM SHAVING?	YES	NO
WHEN WAS YOUR LAST BIRTH?			DO YOU HAVE INGROWN HAIR	YES	NO
ARE YOU LACTATING?	YES	NO	WHAT IS YOUR CURRENT		
ARE YOU MENOPAUSAL?	YES	NO	SHAVING SYSTEM (CHECK ON	WET	ELECTRIC

DO YOU SUFFER FORM ANY OF THE FOLLOWING?

COLD SORES	YES	NO	HERPES	YES	NO	HIV	YES	NO
HEPATITIS B	YES	NO	HEPATITIS C	YES	NO	ROSACEA	YES	NO
ALLERGIES	YES	NO	HYSTERECTOMY	YES	NO	DIABETES	YES	NO
VARICOSE VEINS	YES	NO	ARTHRITIS	YES	NO	CANCER	YES	NO
FIBROMYALGIA	YES	NO	HEART DESEASE	YES	NO	ASTHMA	YES	NO
POOR CIRCULATION			YES NO			EPILIEPSY	YES	NO
HORMONAL CONDITIONS			YES NO			HEMOPHELIA	YES	NO

OTHER:

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