skincare history questionnaire & waiver

PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT YOUR AESTHETICIAN MAY HAVE A BETTER UNDERSTANDING OF YOUR GENERAL HEALTH AND LIFESTYLE, THEREBY ENABLING YOUR AESTHETICIAN TO ACCURATELY ANALYZE AND ASSESS YOUR SKIN CARE NEEDS.

Name:______________________________ DOB:______________________

Address:____

City:__________________________ State:____________ Zip:______________

Home phone:______________________ Cell phone: ______________________

Preferred Contact: ☐ Home ☐ Cell☐ Email Other:______________________

Would you like to be on our e-mail list to receive appointment reminders and info on product / service specials?

☐ Yes ☐ No E-mail Address:______________________________

How did you hear about *DayGlo Med-Spa?*______________________________

Emergency Contact Name:______________________________________

Relationship: ______________________Phone Number:__________________

WHAT CONDITIONS WOULD YOU LIKE TO IMPROVE ABOUT YOUR SKIN? PLEASE CHECK ALL THAT APPLY:

☐ Acne ☐ Uneven Tone/Texture ☐ Fine Lines/Wrinkles

☐ Rosacea ☐ Englared Pores ☐ Sun Damage

☐ Facial Scarring ☐ Age Spots/Freckles ☐ Dehydration

Other Concerns:____

Are you currently having skin treatments? ☐ Yes ☐ No

If yes, what type?______________________________________

HEALTH HISTORY

What type of work do you do?_____________________________________

What is your genetic background? _________________________________

Example: Hispanic, German, Indian, French, etc…

Have you seen a dermatologist in the past year? ☐ Yes ☐ No

If yes, please list reason for visit:______________________________

Are you currently taking medications or supplements? ☐ Yes ☐ No

If yes, please list: ______________________________________

How is your general health? (check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

FEMALE ONLY - Are you currently: ☐ Nursing ☐ Pregnant ☐ Planning to become pregnant # of Pregnancies_______

Please rate your stress level from 1-5 (5 being the highest):

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE EXPERIENCED:

☐ Headaches	☐ Metal Plate	☐ Hernia	☐ Lupus	☐ Thyroid Disorders
☐ Eating Disorder	☐ Asthma	☐ Diabetes	☐ Stroke	☐ Cardiac Problem
☐ High Cholesterol	☐ Hepatitis	☐ Fainting	☐ Contacts	☐ Claustrophobia
☐ Varicose Veins	☐ Epilepsy	☐ Skin Cancer	☐ Dermatitis	☐ Keloid Scarring
☐ Acne	☐ Facial Surgery	☐ Botox/Fillers	☐ Anemia	☐ Broken Capillaries
☐ Laser Treatment	☐ Chemical Peels	☐ Extractions	☐ Herpes Simplex	☐ Microdermabrasion

PAST ILLNESSES: Have you suffered from any past illnesses including chronic kidney or liver disease? Please list all:

____

ALLERGIES: Please list any known allergies ____

Have you ever had any allergic reactions to the following? Please check all that apply:

☐ Aspirin	☐ Salicylates	☐ Milk	☐ Apples	☐ Citrus
☐ Grapes	☐ Fish	☐ Latex	☐ Iodine	

HOME CARE:

What skin care products, if any, are you currently using at home?

☐ Cleanser	☐ Exfoliants	☐ SPF
☐ Toner	☐ Moisturizer	☐ Rx/Specialty

PLEASE MARK IF YOU ARE PRESENTLY USING, OR HAVE EVER USED, ANY OF THE FOLLOWING:

☐ Benzoyl Peroxide	☐ Glycolic Acid (AHA)	☐ Lactic Acid (LHA)	☐ Salicylic Acid (BHA)
☐ Vitamin A	☐ Vitamin C	☐ Hydrocortisone (HC)	☐ Hydroquinone (HQ)
☐ Retin-A	☐ Accutane	☐ Triluma	☐ Metrogel
☐ Finacea (Azeliac Acid)	☐ Differin	☐ Tretinoin	☐ Sulfur

SUN PROTECTION:

Do you use sunscreen? ☐ Yes ☐ No How often?__________________ What level of protection (SPF number)? _______

Do you sunbathe? ☐ Yes ☐ No Do you use a tanning booth? ☐ Yes ☐ No

Most recent prolonged sun exposure? ____

PHOTO RELEASE AGREEMENT

In order to assist the aesthetician with your skin care treatments, it is sometimes necessary for the aesthetician or a member of the staff to take photographs of your face and/or area to be treated. These photos become the property of DayGlo Med-Spa and will remain in your patient file only. None of these photographs will be viewed by anyone outside of the physical and medical staff without your expressed prior written consent.

By signing below, I have entered into this photo release freely; I understand and voluntarily agree to the terms.
By not signing, I refuse to have photos taken and understand that it will be difficult to track the progress of my skin treatments.

Patient Signature: ____ Date: _________________________

FITZPATRICK SKIN TEST

Please circle one box for each category. Be sure to answer ALL questions. Tap the Pen Tool at the top right of the screen to activate the pen. Tap "Done" when finished with this section.

Score	0	1	2	3	4
Eye Color	Light Blue/Gray Green	Blue Grey Green	Brown	Dark Brown	Brownish Black
Natural Hair Color	Sandy Red	Blonde	Dark Blonde, Light Brown	Dark Brown	Black
Color of Your Skin (unexposed to sun)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
Freckles (unexposed to sun)	Many	Several	Few	Incidental	None
What happens when you stay too long in the sun (when not wearing sunscreen)?	Painful, Redness, Blistering, Peeling	Blistering followed by peeling	Burn sometimes followed by peeling	Rarely burn	Never burn
To what degree do you turn brown, if you expose your skin to the sun?	Hardly or none at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
How does your face react to the sun when not wearing sunscreen?	Very sensitive	Sensitive	Normal	Resistant	Never had a problem
When was your last type of exposure to sun or artificial products/lamp etc.?	More than 3 months ago or never	2 to 3 months ago	1 to 2 months ago	Less than a month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun for a prolonged period of time without sunscreen, hat or protective clothing?	Never	Hardly ever	Sometimes	Often	Always

FOR AESTHETICIAN USE ONLY

Skin Type Score	Fitzpatrick Skin Type	Patient Total Score
0-7	I	
8-16	II	
17-25	III	
26-30	IV	
30+	V and VI	

I understand that some skin conditions may require more than one treatment and home care products to achieve the desired results. Results cannot be guaranteed due to individual skin types and condition as well as compliance. I have acknowledged that all of the information provided by me is true and correct to the best of my knowledge.

Patient Signature: ______________________________ Date: ____________________