CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

DATE ____________________
NAME ____________________
ADDRESS ____________________
CITY/STATE/ZIP ____________________
HOME PHONE ____________________
WORK PHONE ____________________
CELL ____________________
EMAIL ____________________
OCCUPATION ____________________
REFERRED BY ____________________

DATE OF BIRTH ________ AGE ________ FAMILY PHYSICIAN ____________________
DO YOU SMOKE? ________ HOW OFTEN? ________ LIVING WITH A SMOKER? ____________________
HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)

◯ ACNE ◯ DEPRESSION ◯ SKIN DISEASE ◯ HIGH BLOOD PRESSURE
◯ COLD SORES ◯ DIABETES ◯ CANCER

LIST OF ALL ALLERGIES ____________________
LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING ____________________
ARE YOU PREGNANT? ________ TRYING TO GET PREGNANT? ________ HORMONE THERAPY? ________
ARE YOU PRONE TO COLD SORES? ____________________

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? ________ DO YOU TAKE SUPPLEMENTS/VITAMINS? ____________________
DO YOU EXERCISE? ________ IF SO, HOW OFTEN: ________ YOUR LAST SUNBURN? ________ DO YOU USE TANNING BEDS? ________
WHEN YOU GO OUT INTO THE SUN, DO YOU (CHECK ONE):

◯ ALWAYS BURN (I) ◯ USUALLY BURN (II) ◯ SOMETIMES BURN (III) ◯ RARELY BURN (IV) ◯ VERY RARELY BURN (V) ◯ NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:

◯ DERMATOLOGIST ◯ PLASTIC SURGEON ◯ AESTHETICIAN ◯ WOULD YOU BE INTERESTED IN COSMETIC SURGERY? ________

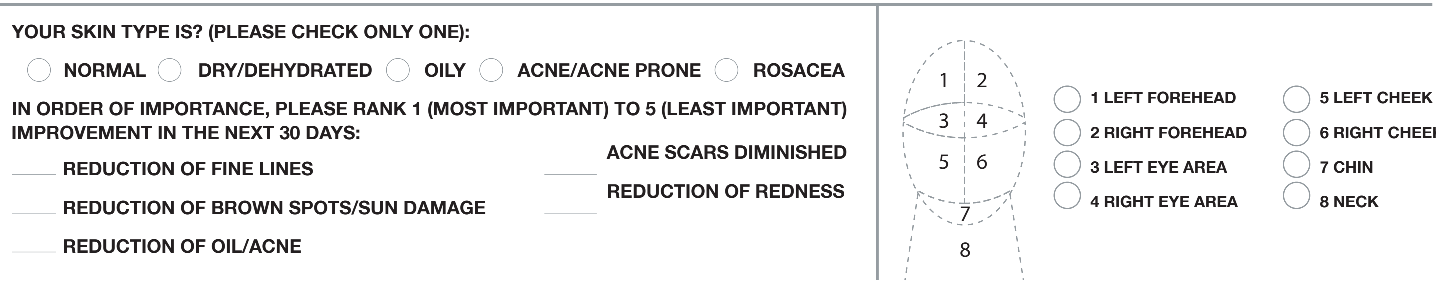
IF YES, WHAT PROCEDURE? ____________________

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)

◯ SUN SPOTS ◯ SKIN LAXITY ◯ DRY / ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING? ____________________
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? ________ IF NOT, WHY? ____________________
CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:

(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)



YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):

◯ NORMAL ◯ DRY/DEHYDRATED ◯ OILY ◯ ACNE/ACNE PRONE ◯ ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

____ REDUCTION OF FINE LINES
____ REDUCTION OF BROWN SPOTS/SUN DAMAGE
____ REDUCTION OF OIL/ACNE
____ ACNE SCARS DIMINISHED
____ REDUCTION OF REDNESS

◯ 1 LEFT FOREHEAD ◯ 5 LEFT CHEEK
◯ 2 RIGHT FOREHEAD ◯ 6 RIGHT CHEEK
◯ 3 LEFT EYE AREA ◯ 7 CHIN
◯ 4 RIGHT EYE AREA ◯ 8 NECK

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/AESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

◯ O² LIFT ◯ THE SIGNATURE LIFT ◯ WRINKLE LIFT PEEL ◯ BETA LIFT PEEL ◯ TCA ORANGE PEEL
◯ ORMEDIC LIFT ◯ LIGHTENING LIFT PEEL ◯ ACNE LIFT PEEL ◯ IMAGE PERFECTION LIFT PEEL

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKINCARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: ____________________ **DATE:** ____________________