Health & Physical - Skin Care Consultation

Name: ________________________________ ***e-mail:*** ________________________________

DOB: ____________________ ***Phone #:*** ______________________***Date:*** ________________

Allergies: ____

Health Related:

Are you pregnant? ____*Yes* ____*No*
Are you nursing? ____*Yes* ____*No*
Do you smoke regularly? ____*Yes* ____*No*
Do you wear sunscreen on a regular basis? ____*Yes* ____*No*
Are you currently taking any antibiotics? ____*Yes* ____*No* ***(these may increase sensitivity)***
Have you visited a tanning booth within the past 3 weeks? ____*Yes* ____*No* ***(if so, your service may have to be rescheduled)***

Do you wear Contact Lenses? ____*Yes* ____*No* ***(please remove contacts prior to microdermabrasion*** ***or if eyes are sensitive)***

Do you have any metal implants? ____*Yes* ____*No* ***where?*** ____________________________________

Do you participate in vigorous aerobic activity or sports? ____*Yes* ____*No* *Times per week:* ______________

Have you ever had?

Cold Sores? ____*Yes* ____*No* ***Herpes?*** ____*Yes* ____*No* ***Hives*** ____*Yes* ____*No* ***Keloids?*** ____*Yes* ____*No*

How often? ________________ *Area of Breakout:* __________________ *Last Breakout:* ______________

Skin Care Related:

Are you currently using products containing:

Glycolic Acid? ____*Yes* ____*No* ***Hydroquinone*** *(Skin Lightener)* ____*Yes* ____*No* ***AHA?*** ____*Yes* ____*No*
How has your skin been reacting to it? ____
Are you currently using Accutane? ____*Yes* ____*No* *How long?* ______________________
Do you currently use wax? ____*Yes* ____*No*
Electrolysis? ____*Yes* ____*No* *or*
Depilatories on you face? ____*Yes* ____*No* *(if so when was your last treatment):*

____

Have you ever had any of the following?

Microdermabrasion? _____Yes _____No if so, when: ____
Chemical Peel? _____Yes _____No if so, when: ____
Laser Resurfacing? _____Yes _____No if so, when: ____
Collagen or Botox? _____Yes _____No if so, when: ____
Facial Surgery: _____Yes _____No if so, when: ____
Do you have permanent make up: _____Yes _____No if so, when: ____

To help us determine a facial regimen suitable for you, describe your skin type (Check all that apply)

___Thick	___Thin	___Saggy	___Firm	___Sensitive	___Resilient	___Normal
___Dry	___Eczema	___Oily	___Acne	___ Prone to breakouts	___Acne Scarred	___Freckled ___Sundamaged
___Melasma	___Psoiasis	___Broken Capillaries	___Mature ___Wrinkled	___Hypo Pigmentation	___Hyper Pigmentation	___T-Zone Combination
___Large Pores	___Small Pores					

Questionnaire:

What improvements would you like to see in your skin? ____
____

What products do you currently use on your skin? ____
____

What type of facial treatment did you last have? ____
____

Consent Agreement

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the provider updated as to any changes in my medical profile and understand that there shall be no liability to Ciao Bella Medical Spa & Vein Clinic should I fail to do so.

Patient's Name: ________________________________ ***Signature:*** ________________________________

Date: ________________________________