give your skin a drink.

AVANTI SKIN CENTERS

SKIN CARE HISTORY QUESTIONNAIRE

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin-care needs.

Date ____/____/____

Name *(please print clearly)*

First Last M.I. ____/____/____ Date of Birth

Street Address City State Zip Code

( ) Cell Phone E-Mail Address

Please check if presently using any of the following. *(please ✓ all that apply)*

❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid ❑ Topical Vitamin C
❑ Hydroquinone ❑ Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin

Which conditions do you want to improve *(please ✓ all that apply)*

❑ Hyperpigmentation (Brown Spots) ❑ Acne/Acne Scarring ❑ Sun Damage ❑ Enlarged Pores
❑ Fine Lines & Wrinkles ❑ Age Spots ❑ Surgical Facial Scars ❑ Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No

FEMALE CLIENTS

Are you on hormone-replacement therapy? ❑ Yes ❑ No
Are you presently taking birth control pills? ❑ Yes ❑ No
Are you pregnant or planning to be? ❑ Yes ❑ No

ALL CLIENTS

Do you use a sunscreen/sunblock? ❑ Yes ❑ No
Do you sunbathe or participate in outdoor activities? ❑ Yes ❑ No

Do you have or have you ever had acne? ❑ Yes ❑ No
Are you using or have you ever used any medications for acne? ❑ Yes ❑ No
Name of medication _____

Have you seen a dermatologist in the past year? ❑ Yes ❑ No
If yes, list doctor's name and reason for visit _____

Are you presently under a doctor's care? ❑ Yes ❑ No
What medications do you take on a regular basis? _____

Have you ever had herpes (cold sores)? ❑ Yes ❑ No
Have you ever been treated with Zovirax or any medication for herpes? ❑ Yes ❑ No

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SKIN CENTERS

SKIN CARE HISTORY QUESTIONNAIRE

Do you have epilepsy or diabetes? ❑Yes ❑No
If yes, you will be treated only with a doctor's release!

Have you had any of the following? ❑Yes ❑No *(please ✓ all that apply)*

❑Cosmetic Surgery ❑Botox Injections ❑Skin Cancer ❑Dermatitis ❑Keloid Scarring
❑Laser Resurfacing ❑Chemical Peels ❑Hepatitis ❑HIV/AIDS ❑Other (Specify) _____

Are you allergic to aspirin? ❑Yes ❑No Are you allergic to iodine or seaweed? ❑Yes ❑No
Do you have any other allergies? ❑Yes ❑No

If yes, list: _____

Do you smoke? ❑Yes ❑No
Do you take nutritional supplements? ❑Yes ❑No
Have you had skin treatments (facials) before? ❑Yes ❑No
Are you currently having facials? ❑Yes ❑No
Have you had electrolysis or waxing in the past week? ❑Yes ❑No
Do you have those services done regularly? ❑Yes ❑No
Have you had permanent cosmetics? ❑Yes ❑No
If yes, where? _____

How is your general health? ❑Excellent ❑Good ❑Fair ❑Poor

What skin-care products are you currently using? _____

What is it about your skin you would like to change? _____

Is there any other information I should know before beginning your treatment? _____

How did you hear about our services? _____

Client Signature _____