IMAGE SKINCARE

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

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

MEDICAL INFORMATION

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
☐ COLDSORES ☐ DIABETES ☐ CANCER

LIST OF ALL ALLERGIES/ALLERGIC _____
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 (CIRCLE 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 ☐ ESTHETICIAN ☐ 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:

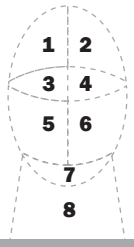
(BAD) ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (FANTASTIC)

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

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

☐ ORMEDIC LIFT ☐ LIGHTENING LIFT ☐ ACNE LIFT ☐ IMAGE PERFECTION LIFT
☐ SIGNATURE LIFT ☐ WRINKLE LIFT ☐ ACNE ADVANCED LIFT ☐ TCA LIFT

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

SIGNATURE: _____ **DATE:** _____

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