

ACQUA BLU MEDICAL SPA & PLASTIC SURGERY CENTER

Skin Care History

Please answer the following questions so that I may have a better understanding of your general health and can appropriately address your skin care needs. Please Print.

Client name: _____

Last

First

Address: _____

Email Address: _____

Telephone #: (home) _____ (work) _____

Age: _____ under 21 _____ 21-30 _____ 31-40 _____ 41-50 _____ 51-60 _____ 60+

How did you hear about us? Please list: _____

Your Health

1. Within the last year, have you been under a plastic surgeon, dermatologist or other physician's care?
____yes ____no
2. Within the last nine months, have you undergone any surgery? ____ yes ____no
3. Have you had any health problems in the past or present? ____ yes ____no
If yes, please specify _____
4. List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly _____
5. Do you smoke? ____ yes ____no
6. Do you exercise regularly? ____ yes ____no
7. Do you follow a restricted diet? ____yes ____no
8. Do you have metal implants, a pacemaker or body piercing? ____yes ____no
9. Do you wear contact lenses? ____yes ____no
10. Rate your level of stress on a scale of 1 to 4 (1=low stress, 4=high stress) _____
11. Are you allergic to aspirin? ____yes ____no Do you have any other allergies?
(including food and latex)? _____

Your Skin

12. Do you have any skin problems pertaining to your face or body? ____yes ____no
If yes, please specify _____
13. What skincare products are you currently using?
Face: ____soap ____cleanser ____toner ____moisturizer ____exfoliator
____eye product
Body: ____soap ____cleanser ____toner ____moisturizer ____exfoliator
____eye product

Exfoliation History

14. Have you ever had chemical peels, microdermabrasion, or any other resurfacing treatments? ____yes
____no
15. Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin care products?
____yes ____no in the last three months ____yes ____no
16. Are you currently using any products that contain the following ingredients?
____glycolic acid ____lactic acid ____any exfoliating scrubs
____any hydroxyl acid products ____vitamin A derivatives (i.e. retinol)

Moisture Hydration

- 17. How much plain water do you consume daily? _____
- 18. How many alcoholic beverages do you consume weekly? _____
- 19. Do you ever experience these conditions on your skin? flakiness
 tightness obvious dryness
- 20. What SPF sunscreen do you use on your face? body?
- 21. Do you sunbathe or use tanning beds? yes no

Capillary Activity

- 22. Do you burn easily in moderate sunlight? yes no
- 23. Do you blush easily when nervous? yes no
- 24. Do you have a tendency to redness? yes no
- 25. Do you suffer from sinus problems? yes no

Oil Secretion

- 26. Do you ever experience oily shine during the day? yes no
- 27. Do you ever experience skin breakouts? yes no

Nerve Activity

- 28. Do you drink more than 4 caffeinated beverages daily? (coffee,tea,soft drinks)
yes no
- 29. Do you ever experience a burning,itching sensation on your skin? yes no
- 30. What is your pain threshold? low medium high
- 31. Have you ever experienced claustrophobia? yes no
- 32. What type of massage pressure do you prefer? light medium firm
- 33. Have you ever had a reaction to the following? cosmetics iodine pollen
 food hydroxyl acids animals fragrance sunscreen other

Female Clients Only

- 34. Are you taking oral contraception? yes no
- 35. Are you pregnant or trying to become pregnant? yes no
- 36. Are you lactating? yes no

Male Clients Only

- 37. What is your current shaving system? electric wet shave
- 38. Do you experience irritation from shaving? yes no

Questions to Discuss Every Visit

- 39. Are you currently having or due for your menstrual period? yes no
- 40. Have you started any new medication since your last visit? yes no
- 41. Have you had any recent dental x-rays? yes no
- 42. What are your skin care goals? _____

Signature: _____ Date: _____

Please Print Name _____