

Skin Care Intake Form

Name: _____ Date: _____

Have you seen a dermatologist in the last two years? Yes No If yes, why? _____

If you are using any prescription creams please list: _____

Please circle all that apply:

High Blood Pressure – Diabetes – Cancer – Pregnant – Allergies: _____

Medications: _____ - Metal Implants (IE pacemaker)

Smoker - Other: _____

Do you wear sunscreen often? Yes No Do you wear contacts? Yes No

List any vitamins or supplements you take: _____

Do you exercise regularly? Yes No

How many glasses of water do you drink daily? _____

Have you ever had microdermabrasion or facial peels? Yes No

If so when was last treatment? _____

Are you using any products containing glycolic acid, alpha hydroxyl acid, or retinoid? Yes No

Have you ever reacted to a skin care product or cosmetic before? Yes: _____ No

Have you ever had a facial before? Yes No When was your last treatment? _____

What was your favorite part? _____

Anything you disliked? _____

If you could change anything about your skin what would it be? _____

What do you hope to gain from this experience today? _____

Please list the products you are currently using (including brand name)

Cleanser: _____ Toner: _____

Scrub: _____ Serum: _____

Moisturizer (please indicate if it has SPF): _____

Mask: _____ Eye Cream: _____

I understand that it is my responsibility to update my esthetician of any changes in the info above.

Signature: _____