



Health History & Skin Analysis for Custom Facials

Date: _____

Name: _____ Gender: _____ Age: _____

Street: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone (Home): _____ Cell: _____

Your occupation:

How did you select me for facial services?

What is the reason for your visit today?

What special areas of concern do you have?

Which conditions would you like to improve?

- Acne Acne scarring Hyperpigmentation
 Age spots Broken capillaries Stretch marks
 Enlarged pores Surgical/facial scars Fine lines & wrinkles
 Other _____

Have you ever had a facial treatment in the past? Yes No

What was/is your favorite part of the facial?

What was/is your least favorite part of the facial?

Have you used any Alpha Hydroxy Acid, Glycolic Acid, Retin-A, Renova, Retinol in the past 48-72 hours?
Yes No

Are you using any other skin thinning products and/or drugs? If yes, list below. Yes No

Are you exposed to the sun on a daily basis or are you considering spending more time in the sun soon?

Do you use a tanning bed? Yes No

How would you describe your skin?

Normal Dry Oily
Combination Sensitive Sun Damaged

How would you rate your skin? (Check one)

- Always burns - never tans Always burns easily - tans slightly
 Burns moderately - tans gradually Seldom burns - always tans well
 Rarely burns – deep tan Never burns – deeply pigmented

Do you ever experience?

Flakiness Tightness Redness Excessive oily shine during day

What is your present skin regimen? Please list brands:

Soap & water only _____
Cleanser _____
Toner _____
Day Moisturizer _____
Night Moisturizer _____
Eye Product _____
Exfoliation (scrubs, clarisonic, etc) _____
Mask _____
Sun block (how often) _____
Shower Gel or Body Lotion _____
Makeup _____

Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin?

Yes No If yes, what are they?

Do you blush easily? Yes No

If yes, what are the contributing factors: Emotions Foods Temperature changes
Other _____

Have you ever had?

Peels Microdermabrasion Facial surgery Cosmetic surgery
Botox Injections Laser resurfacing

How recently? Are you happy with the results?

Are you under treatment for any current skin or medical condition? Yes No

If yes, please explain:

What medications/hormone replacement/vitamins do you presently take?

How does your skin heal? quickly scars pigments

Do you bruise easily? Yes No

Do you get sores/blisters (Herpes Zoster/Shingles)? Yes No

Have you ever used? Accutane Retin-A Renova Topical Antibiotics
Differin Tazarac Hydroquinone Alpha Hydroxy Acids

If yes, when for how long, and how did your skin respond?

Do you have personal or family history of skin cancer? Yes No

Provide detail:

How would you describe you overall health? Excellent Good Fair Poor

Have you had any of the following, past or present? If you answer yes, please specify past or present.

Acne	Yes	No	When? _____
Allergies	Yes	No	
Arthritis or Bursitis	Yes	No	
Asthma	Yes	No	
Blood Pressure	High	Low	Normal
Breast Implant	Yes	No	
Cancer	Yes	No	
Cataracts	Yes	No	
Cholesterol	High	Low	Normal
Claustrophobic	Yes	No	
Diabetes	Yes	No	
Dental fillings	Yes	No	
Diarrhea/constipation	Yes	No	
Dermatitis	Yes	No	
Eczema	Yes	No	
Epilepsy	Yes	No	
Hay Fever	Yes	No	
Headaches	Yes	No	
Heart Disease/Conditions	Yes	No	
Hepatitis	Yes	No	

HIV/AIDS	Yes	No
Hysterectomy	Yes	No
Auto Immune disorder	Yes	No
Infections	Yes	No
Lupus	Yes	No
Menopausal	Yes	No
Metal implants	Yes	No
Migraines	Yes	No
Mitral valve prolapse	Yes	No
Pace Maker	Yes	No
Phlebitis	Yes	No
Psoriasis	Yes	No
Seizures	Yes	No
Serious injury	Yes	No
Sleep problems	Yes	No
Thyroid	Yes	No
Varicose veins	Yes	No

Do you wear contact lenses? Yes No

If yes, to any of the questions above, are you under Dr. supervision? Yes No

What is the current state of your condition?

Have you ever had a reaction to any of the following:

Cosmetics	Metals	Medications	Food	Latex	Iodine	Shellfish
Sunscreen	Pollen	Fragrance	AHAs	Airborne particles		

Other, explain:

FOR WOMEN:

Oral contraceptives? Yes No

If yes, please specify:

Are there any recent changes to your contraceptive treatments? Yes No

If yes, please specify:

Are you pregnant or trying to get pregnant? Yes No

Are you taking hormone replacement? Yes No

If yes, please specify:

Are you experiencing menopausal symptoms? Yes No

If yes, please specify:

FOR MEN:

What do you use to shave? Razor Electric shaver

Do you experience skin breakouts? Yes No

Do you have ingrown hair? Yes No

LIFESTYLE & DIET

What is your stress level? High Medium Low

Do you smoke? Yes No

Do you regularly exercise? Yes No

Do you have food intolerances? Yes No

If yes, please explain:

Do you follow any special diet? Yes No

If yes, please explain:

Do you eat a low fat diet? Yes No

Which foods do you consume on a regular basis?

Fruits Vegetables Dairy/Cheese Eggs Red meat Poultry Fish
Grains/bread Processed sugar Processed meats

How many meals do you eat per day?

How many glasses of water do you consume daily?

How many cups of caffeine-type beverage (coffee, tea, soft drinks) do you consume daily?

1-3 cups 4 or more

How many alcoholic beverages do you consume per week? 0 1-3 4 -6 6 or more

How often do you travel on a plane? Weekly Monthly Quarterly Annually

What does your commute to work look like?

Car Bike Public Transport Walk I don't commute

How many hours do you spend in front of a screen or digital device?

<3 hrs 4-6 hrs 7-9 hrs 10-12 hrs 12+ hrs

How many hours of sleep do you get per night? <3 hrs 3-5 hrs 6-8 hrs 8-10 hrs 10+ hrs

Do you use recreational or medical marijuana? Yes No

In our treatment program, it may be necessary to recommend alterations/additions to your home care regimen. Would that be OK with you? Yes No

Your practitioner will recommend the appropriate schedule for future facial treatments or physician referral in order to achieve your skin improvement goals.

INFORMED CONSENT RELEASE

I, _____, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I also am aware that individual results are dependent upon my age, skin condition, and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will inform my skin care professional immediately.

I release and hold harmless Erin Draper (DBA Evolve Esthetique) from any liability for adverse reactions that may result from this treatment.

POLICIES

We require 48-hour notice for cancellations and 24-hour notice to reschedule wax appointments. Cancellation for Monday must be phoned in on the Friday before. In the event of a late cancellation or no-show appointment the card used to reserve your appointment will be charged \$75 for the facial and \$20 for the wax appointment. If I am able to fill the appointment with a client from the waiting list, I am happy to waive the fee.

NO SHOW appointments are subject to 100% of the cost of the appointment reserved. I am reasonable and understand that life happens, but being stood up will not be tolerated. Please arrive 5 minutes before your scheduled appointment so we have plenty of time for your service.

If you are not satisfied with your service or products, please contact your skin care professional within 24 hours after your appointment so that the situation may be corrected. It is our policy to provide you with the best professional service and products customized for your skin condition.

I have read and understood all of the foregoing information:

Client Signature _____ Date _____