HI-TECH SKIN TRANSFORMATION

1. Name _____DOB_____

2. Address _____

_____

3. Phone _____ email: _____

4. How did you hear about us?

5. What are your skincare goals?

6. Have you ever had a facial treatment? **Yes** **No**
   If yes, describe the type of treatment

7. Have you ever had a body treatment? **Yes** **No**
   If yes, describe the type of treatment?

8. Do you have any special skin problems or concerns pertaining to your face or body? Please specify:

9. Which of the following best describes your skin type? *choose one*
   - _____ Type I – Very light complexion, always burns, never tans
   - _____ Type II – Light complexion, always burns, tans slightly
   - _____ Type III – Moderately light complexion, burns moderately, tans gradually
   - _____ Type IV – Medium Complexion, seldom burns, always tans well
   - _____ Type V – Brown Complexion, rarely burns, deep tan
   - _____ Type VI – Black complexion, never burns, deeply pigmented

10. Have you ever had chemical peels, laser, or microdermabrasion? **Yes** **No**
    If yes, was the procedure done in the last month? **Yes** **No**
11. Do you use Retin-A, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products? **Yes** **No**
    If so, please describe and have you used any in the last 3 months?

12. Have you or are you currently using any acne medication? **Yes** **No**
    Please describe:

13. What skincare products are you currently using? (List brands if known)

14. Have you used any of the following hair removal methods in the past 6 weeks? Please choose all that apply. *Check all that apply.*

_____ Shaving
_____ Waxing
_____ Electrolysis
_____ Tweezing
_____ Threading
_____ Depilatories

15. What areas of concern do you have regarding your skin? *Check all that apply.*

_____ Breakouts/acne
_____ Blackheads/whiteheads
_____ Excessive oil/shine
_____ Rosacea
_____ Broken Capillaries
_____ Redness/ruddiness
_____ Sun spot/liver spot/age spots
_____ Uneven skin tone
_____ Sun damage
_____ Wrinkles/fine lines
_____ Dull/dry skin
_____ Flaky skin
_____ Dehydrated skin
_____ Other:

16. Have you ever had an allergic reaction to any of the following? *Check all that apply.*

_____ Cosmetics
_____ Medicine
_____ Food
_____ Animals
_____ Sunscreens
_____ Iodine
_____ Pollen
_____ AHAs
_____ Fragrance
_____ Shellfish
_____ Latex
_____ Drugs
_____ Other:

17. Please explain any allergies:

18. Have you had any botox, restylane or collagen injections? Yes No If yes, how long ago?

19. **Females Only:**

Are you taking any oral contraceptives? **Yes** **No**

Have you had any recent changes to your contraceptive treatment? **Yes** **No** Please explain:

Are you pregnant, lactating, or trying to become pregnant? **Yes** **No**

Are you experiencing menopause or menopause related changes in your body/skin? **Yes** **No** Please explain:

Are you undergoing any hormone replacement therapy? **Yes** **No**

20. **Males Only:**

What is your current shaving system?

Do you experience irritation from shaving? **Yes** **No**

Do you have problems with ingrown hairs? **Yes** **No**

21. Please use this space for any additional information you would like to share: