HISTORY AND SKIN HEALTH QUESTIONNAIRE

CLIENT INFORMATION

Name_____ **E-Mail Address**_____
Address_____**City**_____**State**_____**Zip**_____
Home Phone_____ **Work Phone**_____ **Fax**_____

B/P_____**T**_____**P**_____**R**_____ **ALLERGIES**_____

MEDICAL INFORMATION

Date of Birth_____ Age_____ Family Physician _____Phone_____
Do You Smoke?____How Often?_____Live w/smoker?_____Do you drink Alcohol?____How Often?_____
Have you ever been treated for: *(please circle)*
Acne Depression Skin Disease High Blood Pressure Cold Sores Diabetes Cancer Sinus
List all medications you are currently taking_____
Are you Pregnant?_____Trying to get Pregnant?_____ Are you on Hormone therapy/Birth Control?_____
Do you wear Contact Lenses?_____

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
Do you exercise?_____How Often?_____When was your last sunburn?_____Do you use tanning beds?_____
Have you had cosmetic surgery?_____
Have you ever been under the treatment plan of a :
Dermatologist_____ Plastic Surgeon _____Aesthetician _____ Over the counter help_____
If so, were you satisfied with the results?_____
What skin care line are you currently using?_____
Cleanser_____ Moisturizer_____ Sunscreen_____
Eye Cream_____ Mask_____ Night Repair Cream_____
Are you using or have you used (when)? ___Alpha/Beta Hydroxy Acids ___Retin-A ___Renova ___Accutane
Circle how you feel about the overall quality of your skin: 1(bad) 2 3 4 5 6 7 8 9 10 (fantastic)
Your skin type is ? (please circle ONLY one)
Normal Dry/Dehydrated Oily Acne/Acne Prone
In order of importance, beginning with 1, make a wish list of what you would like to see improved in your skin in the next 30 days……
_____Reduction in fine lines _____Reduction of brown spots/Sun Damage
_____Reduction of oil/Acne _____Acne scars diminished
Please check all treatments/services that interest you:
_____Professional Skin Care Program _____Microdermabrasion
_____Glycolic/Peel Skin Treatments _____Cosmetic Surgery Procedures

TREATMENT PLAN (To be completed by the Esthetic Nurse Specialist/Physician)

Patient Classification: Fitzpatrick #_____

Morning	Evening
1. Cleanser_____	1.Cleanser_____
2. Anti-Age_____	2. Anti-Age_____
3. Protect_____	3. Repair_____

I hereby authorize and consent to having photographs taken of me and that they may be used as an aid in my treatment, in marketing, or study reporting purposes and that any photographs taken will remain the property of the facility. I understand that my identity will be kept strictly confidential. I also understand that these photographs will help document the progress of my treatment. I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status.

Patient Signature_____ **Date**_____

CLIENT CONSULTATION AND RELEASE FORM

Please read carefully, complete, sign and date this form prior to your treatment.

Name: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

☐ HYDRAFACIAL ☐ MICRODERMABRASION ☐ BLUE LED LIGHT THERAPY ☐ ULTRAMAX

☐ RED LED LIGHT THERAPY ☐ LYMPHATIC/MASSAGE THERAPY

SECTION 1: MEDICAL INFORMATION

- Do any of the following conditions relate to you?

YES	NO	
☐	☐	Accutane or other similar medication
☐	☐	Allergies
☐	☐	Autoimmune disease, HIV, lupus, hepatitis
☐	☐	Blood thinners – Heparin, Coumadin, Warfarin, etc.
☐	☐	Breast feeding, pregnancy
☐	☐	Cancer or post-cancer treatments
☐	☐	Cardiovascular problems
☐	☐	Cold sores or fever blisters without pre-medication
☐	☐	Cortisone or steroid injections
☐	☐	Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
☐	☐	Eczema, psoriasis
☐	☐	Enlarged or painful glands
☐	☐	Epilepsy
☐	☐	Facial waxing services w/in 7-14 days
☐	☐	Heart ailment
☐	☐	Hypertension/high blood pressure
☐	☐	Inflammatory conditions
☐	☐	Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
☐	☐	Keloids, pigmented scars, icepick scars, new scar tissue
☐	☐	Laser procedures, chemical peels, dermabrasion, microdermabrasion
☐	☐	Light sensitive medication
☐	☐	Loose, thin, aged skin
☐	☐	Lymphatic disorder, inflammation of lymph vessels, lymphedema
☐	☐	Medication:
☐	☐	Pacemaker or metal implants
☐	☐	Phlebitis, varicose veins
☐	☐	Recent accident or serious injury
☐	☐	Recent surgical or dental procedure
☐	☐	Rosacea, telangiectasia/couperose
☐	☐	Retin-A, Retinol
☐	☐	Skin abrasions or lesions
☐	☐	Stage III or IV acne
☐	☐	Skin-lightening or bleaching agent
☐	☐	Sunburn
☐	☐	Swollen or infected tonsils
☐	☐	Thyroid conditions

(Continued on next page)

☐	☐	Type I diabetic
☐	☐	Under medical care for an existing or suspected condition or disease
☐	☐	Viral infection, influenza
☐	☐	Other contraindication at discretion of skincare technician or medical practitioner:

- My interest in skincare treatment is primarily for (i.e. skin rejuvenation, acne, hyper-pigmentation, scarring, etc.) _____

  _____

- Specify your areas of concern (i.e. eyes, forehead, etc.) _____

  _____

SECTION 2: CLIENT CONSENT FORM

(Initial each acknowledgement line below)

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. _____*(initial here)*
2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment. _____*(initial here)*
3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen. _____*(initial here)*
4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity. _____*(initial here)*
5. I acknowledge that if I fail to use a minimal sunscreen (SPF 15), I am more susceptible to sunburn, skin damage & hyperpigmentation. _____*(initial here)*
6. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____*(initial here)*
7. I acknowledge that I should avoid use of glycolic products for 2-4 weeks following the treatment. _____*(initial here)*
8. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my ☐ **medical** or ☐ **skincare** professional during and following the treatment. _____*(initial here)*
9. I acknowledge that I am not pregnant/lactating. _____*(initial here)*
10. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____*(initial here)*
11. I acknowledge that I have answered all questions truthfully and completely. _____*(initial here)*
12. I release the instructors, management and staff of Edge Systems Corporation and _____, from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. _____*(initial here)*
13. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. _____*(initial here)*

Client Signature: _____ Date: _____

Skincare Practitioner Signature: _____ Date: _____