

## CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

DATE _____ NAME _____ ADDRESS _____ CITY/STATE/ZIP _____ HOME PHONE _____ WORK PHONE _____ CELL _____ EMAIL _____ OCCUPATION _____ REFERRED BY _____	DATE OF BIRTH _____ AGE _____ FAMILY PHYSICIAN _____ DO YOU SMOKE? _____ HOW OFTEN? _____ LIVING WITH A SMOKER? _____ HAVE YOU BEEN TREATED FOR: (PLEASE CHECK) <input type="radio"/> ACNE <input type="radio"/> DEPRESSION <input type="radio"/> SKIN DISEASE <input type="radio"/> HIGH BLOOD PRESSURE <input type="radio"/> COLD SORES <input type="radio"/> DIABETES <input type="radio"/> CANCER LIST OF ALL ALLERGIES _____ LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING _____ ARE YOU PREGNANT? _____ TRYING TO GET PREGNANT? _____ HORMONE THERAPY? _____ ARE YOU PRONE TO COLD SORES? _____
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### 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

HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? \_\_\_\_\_ DO YOU TAKE SUPPLEMENTS/VITAMINS? \_\_\_\_\_

DO YOU EXERCISE? \_\_\_\_\_ IF SO, HOW OFTEN: \_\_\_\_\_ YOUR LAST SUNBURN? \_\_\_\_\_ DO YOU USE TANNING BEDS? \_\_\_\_\_

WHEN YOU GO OUT INTO THE SUN, DO YOU (CHECK ONE):

ALWAYS BURN (I)    USUALLY BURN (II)    SOMETIMES BURN (III)    RARELY BURN (IV)    VERY RARELY BURN (V)    NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:

DERMATOLOGIST    PLASTIC SURGEON    AESTHETICIAN    WOULD YOU BE INTERESTED IN COSMETIC SURGERY? \_\_\_\_\_

IF YES, WHAT PROCEDURE? \_\_\_\_\_

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)

SUN SPOTS    SKIN LAXITY    DRY / ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING? \_\_\_\_\_

DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? \_\_\_\_\_ IF NOT, WHY? \_\_\_\_\_

CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:

(BAD)   1   2   3   4   5   6   7   8   9   10   (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):

NORMAL    DRY/DEHYDRATED    OILY    ACNE/ACNE PRONE    ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

_____ REDUCTION OF FINE LINES	_____ ACNE SCARS DIMINISHED
_____ REDUCTION OF BROWN SPOTS/SUN DAMAGE	_____ REDUCTION OF REDNESS
_____ REDUCTION OF OIL/ACNE	



### TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/AESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

O<sup>2</sup> LIFT       THE SIGNATURE LIFT       WRINKLE LIFT PEEL       BETA LIFT PEEL       TCA ORANGE PEEL  
 ORMEDIC LIFT       LIGHTENING LIFT PEEL       ACNE LIFT PEEL       IMAGE PERFECTION LIFT PEEL

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.  
 THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKINCARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_