Lasting Impression
CORRECTIVE SKIN CARE

Client History

Name: _____Date: _____

Phone: _____ Date of Birth: _____

Email: _____ Who Referred You: _____

Street Address: _____

City, State, Zip Code: _____

Who Referred You: _____

Post Cosmetic History

Neuromodulator? _____ If so, please explain: _____

Fillers? _____ If so, please explain: _____

Circle All That Apply:

Chemical Peels IPL Fraxel Laser Radio Frequency LED Microcurrent

If so, please explain: _____

PMH: _____

PSx: _____ Cosmetic Sx: _____

Family History: _____

Family Heritage: _____ Redhead Gene: _____

Where You Grew Up: _____

Tanning Ability: _____

Sunburn History: _____ Sun Beds: _____

Skin Cancer? If so, please describe: _____

Fluid Intake: _____ mls/day

Diet: _____ Exercise: _____

Weight: _____ Endocrine: _____ Diabetes: _____ Thyroid: _____

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Menses: _____ Regular? _____ Heavy _____ Menopausal: _____

Hirsutism: _____ Waxing: _____ Threading: _____ Endometriosis: _____ PCOS: _____

Bowel Disease: _____ Celiac: _____ Crohn's: _____ Ulcerative Colitis: _____

Skin Disorders (Circle All That Apply):

Eczema Psoriasis Dermatitis Shingles Cold Sores

If so, please explain: _____

Immune Disorders (Circle All That Apply):

Lupus Rheumatoid Vitiligo Thyroid

If so, please explain: _____

Do you smoke: _____ If so, how often: _____

Caffeine: _____ If so, how many cups/day: _____

Are you pregnant: _____ If so, how many months? _____

Are you taking birth control pills? _____ If so, what brand/type? _____

Hormone Replacement: _____ If so, synthetic or biomimetic: _____

Are you taking oral or topical medication: If so, please list: _____

_____

_____

Do you have persistent acne? _____ If so, please describe: _____

_____

_____

Do you have allergies to cosmetics, foods, or drugs? ____ If so, please list: _____

_____

_____

Please list all skin care products you are currently using, including makeup: _____

_____

_____

_____

Please list all skincare concerns or issues you feel worth mentioning:

_____

_____

_____

_____

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Please describe any important health condition you have currently:

_____
_____
_____
_____
_____

Are you presently under a physician's care for any skin condition or other issue?

_____

If so, please describe:

_____
_____
_____
_____
_____

COVID Vaccine Manufacturer:

Johnson & Johnson Moderna Pfizer

COVID Vaccination Date(s): _____

I understand that the products and services offered are not a substitute for medical care and any information provided by the Skincare Professional is for education purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the Skincare Professional in giving better service and is completely confidential.

I fully understand and agree to the above policies.

_____ _____

(Client Signature) (Date)

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