The Skin and Body Shop

Hair & Vein Removal • Sun Spot Removal • Vibraderm • Skin Care

Name_____ Birthdate _____/_____/_____
Last First Mo Day Yr

Address:_____

City:_____ State:_____ ZIP:_____

Home Phone:( ) _____Cell Phone:( ) _____Work Phone:( ) _____

E-mail_____

How did you hear about us? _____

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
❑	❑	Are you using any prescribed medications? List_____
❑	❑	Are you using any Herbal medications? List_____
❑	❑	Do you take oral anti-coagulant (blood thinning) medication?
❑	❑	Are you allergic to any cosmetic ingredients, medications or foods? List _____
		_____
❑	❑	Are you pregnant or trying to become pregnant?
❑	❑	Do you use oral contraceptives?
❑	❑	Do you use hormone replacement therapy?
❑	❑	Do you smoke? How much? _____ How long?_____
❑	❑	Do you spend a lot of time outdoors or use a tanning bed often?
❑	❑	Do you have any tattoos or permanent makeup?

Please answer the following questions:

Which skin problems concern you the most (Check all that apply):

❑ Sun Damage	❑ Brown spots (Hyperpigmentation)	❑ White spots (Hypopigmentation)
❑ Uneven skin tone	❑ Visible exposed blood vessels	❑ Hard bumps under skin
❑ Enlarged pores	❑ Clogged pores	❑ Blackheads /Whiteheads
❑ Acne	❑ Excessive oiliness	❑ Pimples
❑ Upper lip lines	❑ Wrinkles	❑ Scarring
❑ Sun Spots	❑ Dry patches	❑ Unwanted Hair
❑ Other: _____		

What is your skin type: ❑ Dry ❑ Combination ❑ Oily ❑ Normal

How much water do you consume per day?_____

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

❑ Cleanser _____	❑ Soap _____	❑ Toner _____
❑ Moisturizer _____	❑ Night Cream _____	❑ Mask _____
❑ Eye cream _____	❑ Astringent _____	❑ Glycolic Wash/Cleanser
❑ Scrub _____	❑ Sunscreen_____	❑ Salicylic Wash/Cleanser
❑ Vitamin A Cream	❑ Vitamin C Creams	❑ Alpha or Betahydroxy Cream

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?

Please list_____
_____

Have you ever had any of the following wrinkle fillers or implants:

❑ Collagen ❑ Juvaderm ❑ Restylane ❑ Perlane ❑ Hylaform ❑ Silicone ❑Radiance

❑Other:_____

* If so then when was it done _____and what area? _____

Please check any health problems, past or present:

❑ Seizures	❑ Liver disease	❑ Skin cancer	❑ Hepatitis	❑ Asthma
❑ Hormonal Problems	❑ Diabetes	❑ Cystic Acne	❑ Thyroid	❑ Cancer
❑ High Blood Pressure	❑ Heart problems	❑ Collagen (Lupus, Sarcoid, Scleroderma)	❑ Vasovagal Syncope	

❑Other:_____

Do you have any of the following chronic skin disorders?

❑ Psoriasis	❑ Dermatitis	❑ Eczema	❑ Keloid Scarring
❑ Fever Blisters	❑ Cold Sores	❑ Sun Blisters	❑ Herpes Simplex/Blisters

Have you ever undergone any of the following treatments?

❑ Macrodermabrasion ❑ Acid Peel ❑ Cosmetic Surgery ❑ Accutane

Please Explain_____

Are you currently removing hair by any of the following methods?

❑ Waxing	❑ Tweezing	❑ “Nair” type products
❑ Electrolysis	❑ Laser Hair Removal	

- If so when was it done _____what area _____and what type of laser?_____

Skin and Body Shop Notes:

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