

# *Cary Massage*

## Skin Health Questionnaire

Client Name: \_\_\_\_\_ Birthday    /    /    Dermatologist: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email \_\_\_\_\_

### Please answer the following questions.

Is this your first facial? Y / N Last facial    /    /     
Birth control? Y / N Type: \_\_\_\_\_  
Hormone replacement? Y / N Type: \_\_\_\_\_  
Contact lenses? Y / N  
Smoker? Y / N  
Acne? Y / N  
Have you ever had skin cancer? Y / N Diagnosed when?    /    /     
Allergies to cosmetics, foods, drugs? Y / N List: \_\_\_\_\_  
Taking medications (oral or topical) Y / N List: \_\_\_\_\_  
What is the reason for your visit today? \_\_\_\_\_

Are you presently under a physicians care for any current skin conditions? \_\_\_\_\_

What special areas of concern do you have? \_\_\_\_\_

### Have you ever used any of the following products?

Azelex	Y / N	Accutane	Y / N
Differin	Y / N	Glycolic / alphahydroxy acids	Y / N
Remova	Y / N	Tazarac	Y / N
Retin-A	Y / N		

### Which products do you currently use?

Soap / Cleansing Milk	Y / N	Sunscreen	Y / N	Mask	Y / N
Toner	Y / N	Creams	Y / N	Other	Y / N
Scrub	Y / N				

### Do you suffer from the following:

Eczema	Y / N	Herpes	Y / N	Skin Diseases	Y / N
Fever Blisters	Y / N	Sinus Problems	Y / N	Hepatitis	Y / N

Please explain any YES answers completely: \_\_\_\_\_

Please detail any other medical condition(s) including date of diagnose, treatment and medications taken.

I do hereby understand that the services offered are not a substitute for medical care, and any information provided by the esthetician is for educational proposes only. I understand that the information herein is to aid the esthetician in giving better service and is completely confidential.

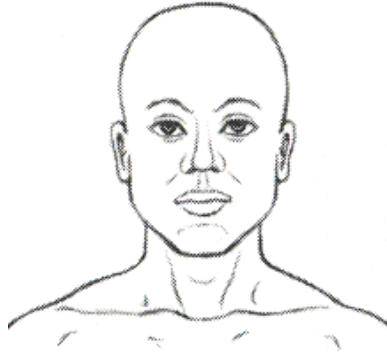
\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

# Skin Classification

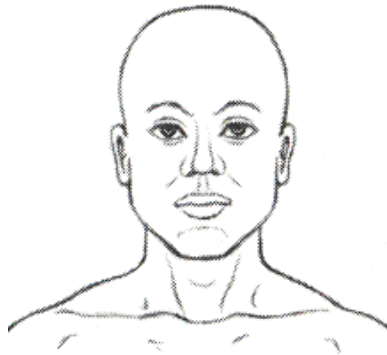
Normal	Y / N	Dry	Y / N	Dehydrated	Y / N
Aging	Y / N	Thin Sensitive Skin	Y / N	Oily	Y / N
Open Pores	Y / N	Comedones	Y / N	Milium	Y / N
Asphyxiated	Y / N	Scars	Y / N	Wrinkles	Y / N
Superficial lines	Y / N	Deep Lines	Y / N	Relaxed Elasticity	Y / N
Good Elasticity	Y / N	Couperose	Y / N	Discoloration	Y / N
Acne	Y / N	How many years: _____			
Vulgaris	Y / N	Chronic	Y / N		
Cystic	Y / N	Rosacea	Y / N		

Date of Treatment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



Type of Treatment	Esthetician	Products Purchased

Date of Treatment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



Type of Treatment	Esthetician	Products Purchased