



# Skincare Client's Profile

Name		Age	Sex	Date
Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you currently have <input type="checkbox"/> sunburn <input type="checkbox"/> windburn	Do you go to tanning booths <input type="checkbox"/> yes <input type="checkbox"/> no		
Do you get facial waxing / electrolysis / or use depilatories?	<input type="checkbox"/> yes, wait approximately 5 days between treatments <input type="checkbox"/> no			
Have you had facial injections or fillers?	<input type="checkbox"/> yes, wait approximately 7 days between treatments <input type="checkbox"/> no			
Do you participate in vigorous aerobic activity or sport? <input type="checkbox"/> yes <input type="checkbox"/> no				
Have you ever had a peel before? <input type="checkbox"/> yes <input type="checkbox"/> no	Within the last 14 days?		<input type="checkbox"/> yes <input type="checkbox"/> no	
Describe your reaction				
Are you recently post-operative? <input type="checkbox"/> yes, from _____ <input type="checkbox"/> no				
Are you allergic to <input type="checkbox"/> milk <input type="checkbox"/> apples <input type="checkbox"/> citrus <input type="checkbox"/> grapes <input type="checkbox"/> aloe vera <input type="checkbox"/> aspirin <input type="checkbox"/> hydroquinone				
Any other allergies? Describe				
Describe your skin <input type="checkbox"/> normal <input type="checkbox"/> oily <input type="checkbox"/> dry <input type="checkbox"/> T-zone / combination <input type="checkbox"/> freckled <input type="checkbox"/> sun damaged <input type="checkbox"/> uneven / blotchy <input type="checkbox"/> mature <input type="checkbox"/> wrinkled <input type="checkbox"/> saggy <input type="checkbox"/> firm <input type="checkbox"/> enlarged pores <input type="checkbox"/> small pores <input type="checkbox"/> acne <input type="checkbox"/> milia <input type="checkbox"/> comedones <input type="checkbox"/> occasional breakouts <input type="checkbox"/> scarred <input type="checkbox"/> cystic acne <input type="checkbox"/> melasma <input type="checkbox"/> flacid <input type="checkbox"/> rosacea <input type="checkbox"/> asphyxiated <input type="checkbox"/> sallow <input type="checkbox"/> perfume-stained <input type="checkbox"/> hypopigmented <input type="checkbox"/> hyperpigmented				
Do you consider your skin <input type="checkbox"/> sensitive <input type="checkbox"/> resilient				
Eye color <input type="checkbox"/> blue <input type="checkbox"/> green <input type="checkbox"/> hazel <input type="checkbox"/> grey <input type="checkbox"/> light brown <input type="checkbox"/> dark brown				
Hair color <input type="checkbox"/> blonde <input type="checkbox"/> red <input type="checkbox"/> light brown <input type="checkbox"/> medium brown <input type="checkbox"/> dark brown <input type="checkbox"/> black <input type="checkbox"/> grey / silver				
Skin tone <input type="checkbox"/> pale / white <input type="checkbox"/> light <input type="checkbox"/> reddish / freckles <input type="checkbox"/> light olive <input type="checkbox"/> medium olive <input type="checkbox"/> dark olive <input type="checkbox"/> brown <input type="checkbox"/> black				
What is your heritage?				
Are you using <input type="checkbox"/> Retin A; how frequently? _____ Where do you apply it? _____ <input type="checkbox"/> Accutane <input type="checkbox"/> hormones / other medications _____ <input type="checkbox"/> glycolic / AHA home care products _____				
How is your skin reacting to them? _____				
Have you ever used any product that caused a bad reaction? Describe.				
Do you <input type="checkbox"/> smoke <input type="checkbox"/> get cold sores / fever blisters <input type="checkbox"/> have telangiectasia / broken surface capillaries				
What is your home regiment?				
What about your skin bothers you, and what would you like to have corrected?				
Do you have any personal preferences we should know about? For example, do you dislike heat/cold or do you dislike certain fragrances?				