BLIX
CLINICAL AESTHETICS

Advanced Skin Care & Laser

Skin Care History Questionnaire and Waiver

Please answer the following questions so that your Skin Care Specialist may have a better understanding of your general health and lifestyle. This helps your Skin Care Specialist to accurately analyze your skin care needs.

Name: _____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Email Address:_____

Health History

What type of work do you do?_____

Have you seen a dermatologist in the past year?: Yes_____ No_____

If yes, please answer the following questions:

Dermatologist's Name:_____

City of business:_____

Reason for visit:_____

Are you presently under a physician's care?: Yes_____ No_____

If yes, please answer the following questions:

Physician's Name:_____

City of business:_____

Reason for visit:_____

Are you currently taking any medications?: Yes_____ No_____

How is your general health?:_____Excellent _____Good _____Fair _____Poor

Please rate your stress level from 1-5 (5 being the highest)

What is your ethnic background? (info for skin typing only):_____

Please circle the following conditions you have or had experienced:

➤hypertension	➤contact lenses	➤high cholesterol	➤asthma	➤stroke
➤metal plate	➤anemia	➤varicose veins	➤hepatitis	➤cancer
➤diabetes	➤lupus	➤seizures	➤tooth fillings	➤epilepsy
➤fainting	➤irregular pulse	➤eating disorder	➤high/low blood pressure	
➤cold sores	➤claustrophobia	➤heart attack	➤autoimmune disorder	

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Do you take nutritional supplements? Yes____ No____

Do you exercise? Yes____ No____

Do you have a tendency to scar? Yes____ No____

Allergies

Have you ever had an allergic reaction to any of the following:

ASPIRIN OR SALICYLATES Yes____ No____

MILK Yes____ No____

APPLES Yes____ No____

CITRUS Yes____ No____

GRAPES Yes____ No____

INGREDIENTS IN SKIN CARE PRODUCTS Yes____ No____

FISH MARINE OR IODINE ALLERGIES Yes____ No____

LATEX Yes____ No____

If you checked YES to any of the above, please explain:

_____

_____

Please list any other known allergies:

_____

Have you ever had Herpes Simplex? Yes____ No____

If yes, have you ever been treated with Denavir (Penciclovir), Zovirax (Acyclivor) or Abreva?

Yes____ No____

Are you being treated for Hepatitis? Yes____ No____

Female clients only:

Are you hormone replacement therapy? Yes____ No____

Are you presently taking birth control pills? Yes____ No____

Are you pregnant or nursing? Yes____ No____

Skin Care History

Are you currently having skin treatments? Yes____ No____

If yes, what type of treatment[s]?_____

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Please check if you are presently using or have used in the past any of the following:
____Benzoyl Peroxide [BP]
____Glycolic Acid [AHA]
____Lactic Acid [AHA]
____Resorcinol
____Salicylic Acid [BHA]

Do you have or had any of the following in the 14 days?

____Facial Cosmetic Surgery	____Botox Injections
____Collagen Injections	____Fillers
____Light Treatments	____Laser Resurfacing
____Microdermabrasion	____Other Laser treatment

Home Care

What skin care products are you currently using at home?

Cleanser_____	Vitamin C_____	Toner_____
SPF_____	Moisturizer_____	Mask_____
Specialty Products_____	Exfoliants/Scrubs_____	

Prescription Products

____Tretinoin [Retin A, Retin A Micro, Renova, Avita]
____Adepalene [Differin]
____Tazarotene [Tazorac]
____Isotretinoin [Accutane]
____Triluma
____Metrogel

Any other topical antibiotics_____

Please Check if you are presently experiencing or have experienced any of the following

____Skin Cancer	____Dermatitis	____Keloid Scarring
____Acne	____Rosacea	____Broken Capillaries
____Treatment Reactions	____Hypopigmentation	____Hyperpigmentation

Sun Protection

Do you use sunscreen? Yes____ No____
What level protection? SPF____
Do you sunbathe or participate in outdoor activities? Yes____ No____

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Do you tan in a tanning booth? Yes____ No____
Have you tanned in a tanning booth in the past 14 days? Yes____ No____

When exposed to the sun do you

____Always burn
____Always burn, sometimes tan
____Sometimes burn, sometimes tan
____Always tan

Do you feel your skin is sensitive? Yes____ No____

What skin conditions do you want to improve?

____Acne and/or breakouts
____Facial Scarring
____Hyperpigmentation [freckles, age spots]
____Hypopigmentation
____Enlarged pores
____Fine lines and wrinkles

Other:_____

Is there any other necessary information your skin care professional should know before beginning your treatment? Yes____ No____
If yes, please explain_____
_____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results can not be guaranteed due to individual skin types and conditions. I understand I need to sign this waiver prior to every treatment provided with ANY changes pertaining to the above questionnaire.

Client Signature_____Date_____

Please check if permission is granted to use pictures for marketing and training purposes. Your name will remain anonymous.
