

Dermologica Consultation Form

Your Health

1. Within the last year, have you been under a dermatologist's or other physician's care? Yes ___ No ___

2. Within the last year have you undergone any surgery? Yes ___ No ___

If yes, please specify _____

3. Have you had any health problems in the past or present? Yes ___ No ___

If yes, please specify _____

4. List any medications, supplements, Vitamins, diuretics, slimming tablets, etc. that you take regularly.

5. Do you smoke? Yes ___ No ___

6. Do you exercise regularly? Yes ___ No ___

7. Do you follow a restricted diet? Yes ___ No ___

8. Do you wear contact lenses? Yes ___ No ___

9. Do you have metal implants, a pacemaker or body piercings? Yes ___ No ___

10. Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress) _____

Your Skin

11. Do you have any special skin problems pertaining to your face or body? Yes ___ No ___

If yes, please specify _____

12. What skin care products are you currently using?

face: __soap __cleanser __toner __moisturizer __masque __exfoliate __ eye products

body: __soap __shower gel __scrubs __oil __body moisturizer __depilatory products __self tanners

Exfoliation History

13. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?

Yes ___ No ___ In the last month? Yes ___ No ___

14. Do you use Accutane, Retin-A, Renova, Adapalene or any other prescription skin products?

Yes ___ No ___ In the last 3 months? Yes ___ No ___

15. Are you currently using any products that contain the following ingredients?

__glycolic acid __lactic acid __any exfoliating scrubs __any hydroxy acid product __vitamin A derivatives (i.e., retinol)

Moisture Hydration

16. How much plain water do you consume daily? _____

17. How many alcoholic beverages do you consume weekly? _____

18. Do you ever experience these conditions on your skin? __flakiness __tightness __obvious dryness

19. What spf sunscreen do you use on your face? _____ Body? _____

20. Do you sunbathe or use tanning beds? Yes ___ No ___

Capillary Activity

21. Do you burn easily in moderate sunlight? Yes____ No____
22. Do you blush easily when nervous? Yes____ No____
23. Do you have a tendency to redness? Yes____ No____
24. Do you suffer from sinus problems? Yes____ No____
25. Do you ever experience oily shine during the day? Yes____ No____
26. Do you ever experience skin breakouts? Yes____ No____

Nerve Activity

27. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) Yes____ No____
28. Do you ever experience a burning, itching sensation on your skin? Yes____ No____
29. What is your pain threshold? ___Low ___Medium ___High
30. Have you ever experienced claustrophobia? Yes____ No____
31. What type of massage pressure do you prefer? ___Light ___Medium ___Firm
32. Have you ever had a reaction to any of the following?
___Cosmetics ___Medicine ___Iodine ___Pollen ___Food ___Hydroxy Acids ___Animals ___Fragrance ___Sunscreen
___Other: _____

Female Clients Only

33. Are you taking oral contraception? Yes____ No____
34. Are you pregnant or trying to become pregnant? Yes____ No____
35. Are you lactating? Yes____ No____

Male Clients Only

36. What is your current shaving system? ___Electric ___Blade
37. Do you experience irritation from shaving? Yes____ No____
38. Do you experience ingrown hairs? Yes____ No____

Questions to Discuss Every Visit

39. Are you currently having or due for your menstrual period? Yes____ No____
40. Have you started any new medication since your last visit? Yes____ No____
41. Have you had any recent x-rays? Yes____ No____
42. What are your skin care goals? _____