IMAGE SKINCARE

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

DATE ____
NAME ____
ADDRESS ____
CITY/STATE/ZIP ____
HOME PHONE ____
WORK PHONE ____
CELL ____
EMAIL ____
OCCUPATION ____
REFERRED BY ____

MEDICAL INFORMATION

DATE OF BIRTH ____ AGE ____ FAMILY PHYSICIAN ____
DO YOU SMOKE? ____ HOW OFTEN? ____ LIVING WITH A SMOKER? ____
HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)

- ○ ACNE ○ DEPRESSION ○ SKIN DISEASE ○ HIGH BLOOD PRESSURE
- ○ COLDSORES ○ DIABETES ○ CANCER

LIST OF ALL ALLERGIES/ALLERGIC ____
LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING ____
ARE YOU PREGNANT? ____ TRYING TO GET PREGNANT? ____ HORMONE THERAPY?
ARE YOU PRONE TO COLD SORES? ____

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? ____ DO YOU TAKE SUPPLEMENTS/VITAMINS? ____
DO YOU EXERCISE? ____ IF SO, HOW OFTEN: ____ YOUR LAST SUNBURN? ____ DO YOU USE TANNING BEDS? ____
WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE CHECK ONE):

○ ALWAYS BURN (I) ○ USUALLY BURN (II) ○ SOMETIMES BURN(III) ○ RARELY BURN (IV) ○ VERY RARELY BURN (V) ○ NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:

○ DERMATOLOGIST ○ PLASTIC SURGEON ○ ESTHETICIAN ○ WOULD YOU BE INTERESTED IN COSMETIC SURGERY? ____

IF YES, WHAT PROCEDURE? ____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)

○ SUN SPOTS ○ SKIN LAXITY ○ DRY / ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING? ____
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? ____ IF NOT, WHY? ____
CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:

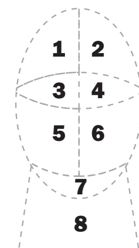
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):

○ NORMAL ○ DRY/DEHYDRATED ○ OILY ○ ACNE/ACNE PRONE ○ ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

____ REDUCTION OF FINE LINES
____ REDUCTION OF BROWN SPOTS/SUN DAMAGE
____ REDUCTION OF OIL/ACNE
____ ACNE SCARS DIMINISHED
____ REDUCTION OF REDNESS



- ○ 1 RIGHT FOREHEAD
- ○ 2 LEFT FOREHEAD
- ○ 3 LEFT EYE AREA
- ○ 4 RIGHT EYE AREA
- ○ 5 LEFT CHEEK
- ○ 6 RIGHT CHEEK
- ○ 7 CHIN
- ○ 8 NECK

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

○ ORMEDIC LIFT ○ LIGHTENING LIFT ○ ACNE LIFT ○ IMAGE PERFECTION LIFT
○ SIGNATURE LIFT ○ WRINKLE LIFT ○ ACNE ADVANCED LIFT ○ TCA LIFT

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: ____ DATE: ____

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