

SPA VITORIA

CLIENT INFORMATION

Please check all that apply:

_____ Your location was convenient for me

_____ Magazine or other publication

_____ Internet

_____ Spa Finder

_____ Other _____

_____ A referral from _____

Name _____ Date _____

Date of Birth _____ Age _____ Male _____ Female _____

Address _____

City/State/Zip _____

Home Phone () _____ Cell Phone () _____

Email Address _____

Employer _____ Work Phone () _____

Emergency Contact _____ Relationship _____

Phone () _____ Alternate Phone () _____

Reason for today's visit _____

PLEASE COMPLETE ALL FOUR PAGES

Patient Name: _____ Date: _____

Have you seen a Dermatologist within the last 5 years? YES NO

Are you under his/her care now? YES NO

Are you currently taking any medications? YES NO

If yes, please specify _____

List vitamins/supplements taken regularly: _____

Do you have any known allergies? YES NO

If yes, please specify _____

Do you have any of the following health conditions? Check all that apply:

____ Asthma ____ Arthritis ____ Diabetes ____ Cancer ____ Heart Disease

____ Hepatitis ____ HIV ____ Hormonal ____ Hysterectomy

How often do you consume the following foods? 1 = Frequently 2 = Infrequently 3 = Never

____ Caffeine ____ Smoked Foods ____ Dairy ____ Alcohol ____ Red Meat

____ Salt ____ Fried Foods ____ Soda ____ Sweets

What is your skin type?

____ Dry ____ Normal to Dry ____ Normal ____ Normal to Oily ____ Oily

Do you smoke? YES NO

Do you suntan? YES NO If yes, how often? _____

Do you use sunscreen? YES NO

Have you ever used Hydroquinone (skin lightener)? YES NO

Have you ever used Retin-A? YES NO

If yes, what did you use it for? ____ Acne ____ Fine Lines

Your stress level is: LOW MEDIUM HIGH

Have you ever had any of the following? Check all that apply:

____ Cold Sores ____ Fever Blisters ____ Herpes ____ Hives ____ Keloids

What specifically concerns you about your skin? Check all that apply:

____ Dehydration ____ Excess Oil ____ Pore Size

____ Whiteheads ____ Blackheads ____ Acne

____ Sensitivities ____ Active Lesions ____ Dark Spots (example: Melasma, Hyperpigmentation)

____ Signs of aging/wrinkles ____ Visible Capillaries (example: Rosacea, Couperose)

Patient Name: _____ **Date:** _____

What products are you currently using? Check all that apply (include brand if possible):

_____ Cleanser _____

_____ Toner _____

_____ Anti-aging product _____

_____ Eye cream _____

_____ Facial lotion _____

_____ Sunscreen _____

_____ Other _____

Have you ever had an allergic reaction to products you have applied to your skin? YES NO

If yes, which products did you react to? _____

Have you ever had a peel? YES NO If yes, when was your last peel? _____

How often do you get peels? _____

If no, are you interested in learning more about peels? YES NO

Have you ever had any injectibles/fillers? (Example: Botox, Juvederm/Restylane) YES NO

If yes, please list _____

If no, are you interested in learning more about injectibles/fillers? YES NO

Have you had any laser procedures performed on your face? YES NO

If yes, please list _____

If no, are you interested in learning more about laser procedures? YES NO

Have you had any previous aesthetic (cosmetic) surgeries? YES NO

If yes, please list procedure(s) and date in which surgery was performed:

If no, are you interested in learning more about a specific surgical procedure? YES NO

If yes, what procedure(s) are you interested in learning more about? Check all that apply:

_____ Ear Surgery

_____ Nose Surgery

_____ Arm Lift

_____ Body Contouring

_____ Breast Augmentation

_____ Breast Lift

_____ Breast Reconstruction

_____ Breast Reduction

_____ Brow Lift

_____ Eyelid Surgery

_____ Facelift

_____ Laser Peels

_____ Liposuction

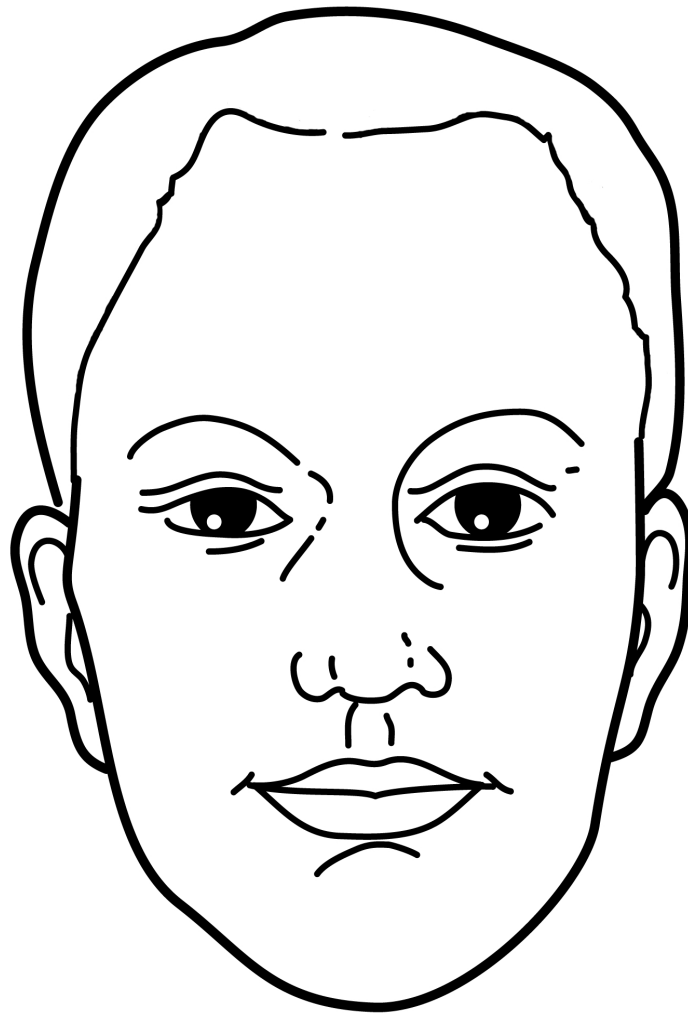
_____ Tummy Tuck

_____ Spider Vein Injections

_____ Other _____

Patient Name: _____ Date: _____

Please mark all areas of concern:



NOTES: _____

