IMAGE
SKINCARE

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

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

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
○ COLD SORES ○ DIABETES ○ CANCER
LIST OF ALL ALLERGIES ______
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 (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 ○ AESTHETICIAN ○ 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

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/AESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

○ O² LIFT ○ THE SIGNATURE LIFT ○ WRINKLE LIFT PEEL ○ BETA LIFT PEEL ○ TCA ORANGE PEEL
○ ORMEDIC LIFT ○ LIGHTENING LIFT PEEL ○ ACNE LIFT PEEL ○ IMAGE PERFECTION LIFT PEEL

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

SIGNATURE: ______ DATE: ______

Age later™