jody
AESTHETICS
San Angelo Acne Clinic

Confidential Skin Health Survey

Today's Date _____
First Name _____ Last Name_____ DOB _____
Street _____ Apt. # ____ City _____ State _____
Zip _____
Phone: Home ( ) _____ Work ( ) _____ Mobile _____
Email _____
Dermatologist/Physician _____
Emergency Contact _____
Your Occupation _____
Referred by _____

1. Is this your first facial?_____
2. What is the reason for your visit today?_____
3. What special concern do you have ? _____
4. Are you presently under a physician's care? _____
5. Are you pregnant?_____
6. Are you taking birth control pills?_____
7. Hormone replacement? _____ If so, what? _____
8. Do you wear contact lenses?_____
9. Do you smoke?_____
10. How often do you experience stress?_____
11. Have you had skin cancer?_____
12. Are you now using (or used in the past): Azelex _____Differin _____
    Renova_____ Retin-A_____ Tazarac _____
    Glycolic or Alpha-hydroxy acids?_____
13. Are you now or have you ever used Accutane?_____
    If so, when and for how long? _____
14. Do you have acne? _____ Experience frequent blemishes? _____
15. Do you have any allergies to cosmetics, foods, or drugs? _____
16. Are you presently taking any medications (oral or topical)? _____
    If so please list _____
17. What skin care products do you presently use? _____

_____

Please circle if you have had any of the following:

Asthma	Fever blisters	Hysterectomy	Sinus problems
Cardiac problems	Headaches-- chronic	Immune disorders	Skin diseases
Depression or anxiety	Hepatitis	Lupus	Urinary or kidney problems
Eczema	Herpes	Metal bones/ pins/plates	Pacemaker
Epilepsy	High Blood Pressure		

Please explain above problems or list any other significant issues.

_____

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I understand that the services offered are not a substitute for medical care and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

SPA POLICIES

1. Professional consultation is required before initial dispensing of products.
2. My active discount rate is only effective for clients visiting every four weeks.
3. I do not give cash refunds.
4. I require a 24-hour cancellation notice.

I fully understand the above spa policies.

Client signature_____
Date_____

Therapist signature _____
Date_____