SKIN CONSULTATION FORM

Name ____ Date:_____________________

Address ____

Email Address:____

Telephone Home __________________ Cell _______________

Date of Birth _________________

Do you have any allergies to skin care products? ____________
If yes, please explain ____
____

What is the best description for your skin type? Normal, Oily, Dry, or Combination
____

Please describe how your skin feels 1) In the morning ____________________________
____
2) In the late afternoon ____
____

Are you pregnant? ____________

Please describe your current skin care regimen. Do you use cleanser, toner, moisturizer, sunscreen, eye cream, etc? ____
____
____
____

Do you exfoliate your skin? ______ If yes, how often? ___________________________

How much water do you drink per day? ______________________________________

Do you smoke? Yes________ No________

Are you currently taking any medications? If yes, please explain ___________________
____

Have you had any surgical or non-surgical cosmetic procedures in the last two years____?
If yes, Please explain ____
____
____

****Please note all information is strictly confidential**