SpaBlue Client Skin Story

Date:___________

First Name: _________________________ Middle Initial: ________ Last Name: __________________________
Address: ____
City: ____ State: _________ Zip Code: __________________
Home Phone: (____)____________Mobile Phone: (____)______________ Work Phone: (___)_________________
eMail: ____ Date of Birth: ______/_____/_______Age: _________

How would you describe your skin? □ Oily □ Sensitive □ Dry □ Normal □ Combination

Do you experience any of the following?
□ Breakthrough oily shine □ Break-Outs □ Flakiness □ Latex® Allergy □ Tightness
□ Obvious Dryness □ Tendency to Redness □ Burning in Moderate Sunlight

Have you received any of the following procedures?
□ Chemical Peel □ Facial Ultrasound □ Eyelash/Eyebrow Tinting
□ Microdermabrasion □ Facial □ Waxing
□ Dermaplaning □ Laser Hair Removal

Have you ever used any of the following topical/oral medications?
□ Accutane® □ Differin® □ Retin-A® □ Avage®
□ Renova® □ Tazarac® □ Trentinoin® □ EpiDuo®
□ Hydroquinone® □ Topical Antibiotics □ Alpha Hydroxy Acids □ Ziana®
Other: ____

Current Medications (Include Birth control and OTC)
1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________
6. ___________________________________

Current Supplements/Vitamins
1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________
6. ___________________________________

Habits	Never	Frequency of Use	Number of Years	Date Last Used
Tobacco		Packs/Day		
Alcohol		Beverages/Day		
Caffeine		Cups/Day		

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Have you had any of the following conditions?

Acne	□ Yes □ No
Arthritis	□ Yes □ No
Diabetes	□ Yes □ No
Severe Headache/Migraine	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No
Seizures	□ Yes □ No
Cancer	□ Yes □ No
Heart Condition	□ Yes □ No
Pacemaker/Medical Implants	□ Yes □ No
Hepatitis	□ Yes □ No
Skin Disorder (i.e. Dermatitis)	□ Yes □ No
Hypertrophic scaring (i.e. Keloids)	□ Yes □ No
Bleeding Disorder (i.e. Anemia)	□ Yes □ No
HIV/AIDS	□ Yes □ No
Thyroid Disease	□ Yes □ No
Lupus	□ Yes □ No

REVIEW OF SYSTEMS

How many ounces of water do you consume daily? ____________________

How much caffeine do you consume daily? ___________________

Do you currently have sunburn/windburn? □ Yes □ No

Do you use a tanning booth? □ Yes □ No

Are you pregnant or breast feeding? □ Yes □ No

Do you wear contact lenses or eyeglasses? □ Yes □ No

Do you have intolerance to heat or cold? □ Yes □ No

Do you have any other medical concerns
that have not been covered in this form? □ Yes □ No

If yes, please explain

____

____

Do you understand that some procedures are followed by a period of healing before the tissue returns to normal and the final result is apparent? □ Yes □ No

____ ___________________

Client Signature Date

____ ____________________

Parent/Guardian Signature (If under the age of 18) Date