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**Facial intake form**

**Confidential Skin Health Survey**

Please Print: Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Phone H (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dermatologist/Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By

\_\_\_ Friend \_\_\_ Mailer \_\_\_ Newspaper \_\_\_ Magazine Ad \_\_\_ other

Esthetician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is this your first facial?

Yes No

2. What is the reason for your visit today?

Tazarac Peels HIFU skin tightening

3. What special areas of concern do you have?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are you presently under a physician’s care for any current skin condition or other problem?

Yes No

Please Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Are you pregnant?

Yes No

6. Are you taking birth control pills?

Yes No

7. Hormone replacement?

Yes No

Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you wear contact lenses?

Yes No

9. Do you smoke?

Yes No

10 Do you often experience stress?

Yes No

11. Have you had skin cancer?

Yes No

12. What products do you use presently?

Soap Cleansing milk Toner Scrub Mask Creams Sunscreen Other

13. Are you now using (or used in the past):

Azelex Differin Renova Retin-A

If so, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Are you now using, or have you ever used Accutane?

Yes No

If so, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Do you have acne?

Yes No

Experience frequent blemishes?

Yes No

15. Do you have any allergies to cosmetics, foods, or drugs?

Yes No

If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Are you presently taking medications –oral or topical?

Yes No

If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle if you are affected by or have any of the following:

Asthma Hepatitis Metal bone, pins, or plates Cardiac problems Herpes Pacemaker Eczema High blood pressure Psychological problems

Epilepsy Hysterectomy Sinus problems

Fever blisters Immune disorders Skin diseases –other Headaches-chronic Lupus Urinary or kidney problems

Please explain above problems or list any significant others:

**Help Us Treat You the Right Way.....**

Skin type is often categorized according to the Fitzpatrick Skin Type Scale which ranges from very fair (skin type I) to very dark (skin type VI). Genetic disposition, individual reaction to sun exposure and tanning habits are considered. **Please mark the Score (0-4) and then add the scores on the right side of the page.**

**Genetic Disposition**

What is the color of your eyes?

**0** –Light blue\Gray\Green **1** – Blue\Gray\Green **2** – Blue **3** – Dark Brown **4** – Brownish Black **Score: \_\_\_\_\_\_**

What is the natural color of your hair?

**0** – Sandy Red **1** – Blonde **2** – Auburn/ light Blonde **3** – Dark Brown **4** – Black **Score: \_\_\_\_\_\_**

What is the color of your skin (non-exposed areas)?

**0** – Reddish **1** – Very Pal e **2** – Pale w/Beige Tint **3** – Light Brown **4** – Dark Brown **Score: \_\_\_\_\_\_**

Do you have freckles on unexposed skin?

**0** – Many **1** – Several **2** – Few **3** – Incidental **4** – None **Score: \_\_\_\_\_\_**

**Total Score for Genetic Disposition: \_\_\_\_\_\_\_**

**Reaction to Sun Exposure**

What happens when you stay too long in the sun?

**0** – Painful redness, blistering, peeling **1** – Moderate redness, blistering followed by peeling

**2** – Mild burn sometimes followed by peeling **3** – Rare Burns **4** – Never had burns **Score: \_\_\_\_\_\_\_**

To what degree do you turn brown?

**0** – Never **1** – Light color tan **2** – Reasonable tan **3** – Tan easy **4** – Tans darkly quickly **Score: \_\_\_\_\_\_\_**

Do you turn brown within several hours after sun exposure?

**0** – Never **1** – Seldom **2** – Sometimes **3** – Often **4** – Always **Score: \_\_\_\_\_\_\_**

How does your face react to the sun?

**0** – Sensitive **1** – Seldom **2** – Sometimes **3** – Normal **4** – Resistant **Score: \_\_\_\_\_\_\_**

**Total score for Reaction to Sun Exposure: \_\_\_\_\_\_\_\_**

**Tanning Habits**

How many months ago was your body last exposed to sun, tanning light or tanning cream?

**0** – More than 3 months **1** – 2-3months **2** – 1-2months **3** – Less than a month **4** – 2 weeks **Score: \_\_\_\_\_\_\_**

Has the area to be treated ever been exposed to the sun?

**0** – Never **1** – Seldom **2** – Sometimes **3** – Often **4** – Always **Score: \_\_\_\_\_\_\_**

**Total score forTanning Habits: \_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Skin type score** | **Fitzpatrick Skin Type** |

**0 to 7 I**

**8 to 16 II**

**17 to 25 III Total score of 3 sections: \_\_\_\_\_\_\_\_**

**25 to 30 IV**

**over 30 V – VI Fitzpatrick SKIN TYPE \_**\_\_\_\_\_\_

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Client

[Print Name] Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness

[Print Name] Signature Date

I understand that the services offered are not a substitute for medical care, and any information provided by the aesthetician or other licensed medical professional is for educational purpose only and not diagnostic or prescriptive in nature. I understand that the information contained is to aid the aesthetician or other licensed medical professional in giving better service and is completely confidential.

**Policies:**

1. Professional consultation is required before initial dispensing of products.

2. We do not give cash refunds and we require a 24-hour cancellation notice.

I fully understand and agree to the above policies and consent to having the Oasis Facial procedure performed by trained personnel at Oasis MedSpa.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date