BUFF'D WELLNESS

Skincare Health History Form

Name: _____ Phone: _____
Address: _____
E-mail: _____ Occupation: _____
Age:_____ Date of Birth: _____ ( ) Female ( ) Male (Tells me how you use your body)
How did you hear about me? _____
In case of Emergency: _____ Relation: _____ Phone: _____

Have you ever experienced a professional facial? Yes No When? _____
What is your main concern today for treatment? _____
Have you been under the care of a physician, dermatologist or other medical professional within the past year? No Yes, explain:_____
Any recent cosmetic surgery, including injections, permanent makeup/brows, plastic surgery? No Yes, explain:_____
List any medications, prescription/over the counter, (including vitamins, herbal supplements, aspirin, etc.) that you take regularly: _____
_____
Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? No Yes, describe:____ _____
Have you used any of these products in the last 3 months? No Yes
Have you used an acne medication? No Yes, when? _____ Which drug?_____
Do you form thick or raised scars from cuts or burns? No Yes
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? No Yes, describe: _____
List your daily consumption of: Water _____ Caffeine _____ Alcohol _____
Any skin cancer? No Yes. Family History? No Yes explain:_____
When you go out in the sun do you: (check one)
(1)Always, (2)Usually, (3) Sometimes, (4) rarely, (5) Very Rarely, (6) Never Burn?
Do you prefer to be outdoors? Sometimes? Often? Do you use tanning beds? No Yes
When was your last sunburn?_____ To what degree?_____
Do you smoke? No Yes Live with a smoker? No Yes
Do you follow a restricted diet? No Yes,specify:_____
Do you exercise regularly? No Yes_____ _____
What is your current stress level? High Medium Low Normally?_____
Do you experience any problems sleeping? No Yes Staying asleep? No Yes Normal # of hours?_____
Do you sleep on your back, side, or stomach?(Circle one or all) Do you have Cotton or Silk pillow cases?
Do you have any metal implants or wear a pacemaker? No Yes
Do you wear contact lenses? No Yes
How do you currently feel about the overall quality of your skin? Rate 1(Bad) -10 (Love It!)_____
What would you like to improve about your skin? _____

What is your home skincare regimen? (Please provide product name and am/pm use to all that apply)

Cleanser_____ Toner_____ Exfoliator_____

Mask_____ Serums_____ Moisturizer/SPF_____

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Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs
Fragrance Shellfish Latex Drugs Other: _____

If yes, please explain: _____

Female Clients Only:

Are you taking oral contraceptives? No Yes, specify:____ _____

Any recent changes to or from your contraceptive treatment? No Yes, If so, what and when?

_____

Are you pregnant or trying to become pregnant? No Yes Are you lactating? No Yes

Any menopause problems? No Yes, specify: _____

Please use this space to complete answers where space was insufficient.

_____
_____
_____
_____
_____
_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Cancellation Policy

You are responsible for your appointments! Arrive 10min early. If you need to reschedule please do so ASAP, if less than 24 hours you may be charged $50 or 50% whichever is greater. Within 2 hours or Fail to show/ without call, you will be charged the full amount. I fully understand and happily agree to these policies. _____Initials

_____ _____ Date:_____

Client Signature Michelle Buffkin, LMT, LE