

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

DATE _____ NAME _____ ADDRESS _____ CITY/STATE/ZIP _____ HOME PHONE _____ WORK PHONE _____ CELL _____ EMAIL _____ OCCUPATION _____ REFERRED BY _____	DATE OF BIRTH _____ AGE _____ FAMILY PHYSICIAN _____ DO YOU SMOKE? _____ HOW OFTEN? _____ LIVING WITH A SMOKER? _____ HAVE YOU BEEN TREATED FOR: (PLEASE CHECK) <input type="radio"/> ACNE <input type="radio"/> DEPRESSION <input type="radio"/> SKIN DISEASE <input type="radio"/> HIGH BLOOD PRESSURE <input type="radio"/> COLD SORES <input type="radio"/> DIABETES <input type="radio"/> CANCER LIST OF ALL ALLERGIES _____ LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING _____ ARE YOU PREGNANT? _____ TRYING TO GET PREGNANT? _____ HORMONE THERAPY? _____ ARE YOU PRONE TO COLD SORES? _____
---	--

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? _____ DO YOU TAKE SUPPLEMENTS/VITAMINS? _____

DO YOU EXERCISE? _____ IF SO, HOW OFTEN: _____ YOUR LAST SUNBURN? _____ DO YOU USE TANNING BEDS? _____

WHEN YOU GO OUT INTO THE SUN, DO YOU (CHECK ONE):

ALWAYS BURN (I) USUALLY BURN (II) SOMETIMES BURN (III) RARELY BURN (IV) VERY RARELY BURN (V) NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:

DERMATOLOGIST PLASTIC SURGEON AESTHETICIAN WOULD YOU BE INTERESTED IN COSMETIC SURGERY? _____

IF YES, WHAT PROCEDURE? _____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)

SUN SPOTS SKIN LAXITY DRY / ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING? _____

DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? _____ IF NOT, WHY? _____

CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:

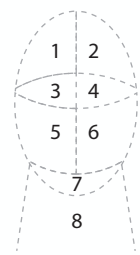
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):

NORMAL DRY/DEHYDRATED OILY ACNE/ACNE PRONE ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

____ REDUCTION OF FINE LINES	____ ACNE SCARS DIMINISHED
____ REDUCTION OF BROWN SPOTS/SUN DAMAGE	____ REDUCTION OF REDNESS
____ REDUCTION OF OIL/ACNE	



<input type="radio"/> 1 LEFT FOREHEAD	<input type="radio"/> 5 LEFT CHEEK
<input type="radio"/> 2 RIGHT FOREHEAD	<input type="radio"/> 6 RIGHT CHEEK
<input type="radio"/> 3 LEFT EYE AREA	<input type="radio"/> 7 CHIN
<input type="radio"/> 4 RIGHT EYE AREA	<input type="radio"/> 8 NECK

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/AESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

<input type="radio"/> O ² LIFT	<input type="radio"/> THE SIGNATURE FACELIFT® PEEL	<input type="radio"/> WRINKLE LIFT® PEEL	<input type="radio"/> BETA LIFT™ PEEL	<input type="radio"/> TCA ORANGE PEEL®
<input type="radio"/> ORMEDIC LIFT™ PEEL	<input type="radio"/> LIGHTENING LIFT® PEEL	<input type="radio"/> ACNE LIFT® PEEL	<input type="radio"/> PERFECTION LIFT™ PEEL	<input type="radio"/> IMAGE FACIAL

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
 THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKINCARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: _____ DATE: _____