Client Name: ______________________ Date: __________
Skin Care Therapist: ______________________

Personal History Questionnaire

What skin conditions would you like to improve? ______________________
What expectations do you have from your facial treatment? ______________________
What do you enjoy the most from a facial treatment? ______________________
When was your last facial? ______________________
Do you wear contact lenses? ______ ❑ Yes ❑ no
Do you follow a special diet? ______ ❑ Yes ❑ no
Do you supplement your diet with vitamins? ______ ❑ Yes ❑ no
Are you on medication for food allergies? ______ ❑ Yes ❑ no
Do you drink 8 glasses of water daily? ______ ❑ Yes ❑ no
Do you smoke? If so, how much? ______ ❑ Yes ❑ no
Do you have any cosmetic allergies? ______ ❑ Yes ❑ no
Are you allergic to latex gloves? ______ ❑ Yes ❑ no
Are you experiencing stress and nervous tension? ______ ❑ Yes ❑ no
Do you have eczema, psoriasis or dermatitis? ______ ❑ Yes ❑ no
Do you have a history of fever blisters? ______ ❑ Yes ❑ no
Do you have a history of skin cancer? ______ ❑ Yes ❑ no
Are you claustrophobic? ______ ❑ Yes ❑ no
Do you use tanning beds? ______ ❑ Yes ❑ no
Are you currently taking hormone replacement therapy? ______ ❑ n/a ❑ Yes ❑ no
Are you currently taking birth control pills? ______ ❑ n/a ❑ Yes ❑ no
Are you pregnant? ______ ❑ n/a ❑ Yes ❑ no
Are you nursing? ______ ❑ n/a ❑ Yes ❑ no
Do you have a pacemaker? ______ ❑ Yes ❑ no
Do you participate in vigorous aerobic activity or sports? ______ ❑ Yes ❑ no
Are you currently having facial waxing, electrolysis, or using depilatories? ______ ❑ Yes ❑ no
Are you considering facial cosmetic surgery? ______ ❑ Yes ❑ no
Are you under a dermatologist's care? ______ ❑ Yes ❑ no
If yes, what is the doctor's name? ______ ❑ Yes ❑ no
Do you have a history of blistering sunburns as a child or as an adult? ______ ❑ Yes ❑ no
Do you use a sun block of SPF 15 or higher daily? ______ ❑ Yes ❑ no
What is your approximate sun exposure time? Occupational ____ Recreational ____
Are you currently taking Accutane or using Retin-A, Renova, Avita or Differin? ❑ Yes ❑ no
If YES , what strength? __________ How frequently? __________
Are you currently using Glycolic Acid products? ______ ❑ Yes ❑ no
If YES , what strength? __________ How frequently? __________
Please check any health problem, past or present:

❑ Diabetes ❑ Heart ❑ Hepatitis ❑ Thyroid Cancer
❑ Hormonal Problem ❑ Acne ❑ High Blood Pressure

Current cosmetic skin care program includes:

Soap/Cleanser ______________________
Toner/Astringent ______________________
Moisturizer ______________________
Eye Cream/Eye Gel ______________________
Surface Peel/Facial Exfoliator ______________________
Mask ______________________

110 Lovett Drive
Greenville, SC 29624
www.SkinbyStephanie.com

SCIENCE CEUTICALS