Skincare History Questionnaire and Waiver

106 -175 Chestermere Station Way Chestermere, Alberta T1X 0A4 Phone: 587-349-5850 Fax: 403-235-6209
Email: medspa@lifepathwellness.com Web: www.medspachestermere.com

Please answer the following questions so that your Skincare Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skincare Therapist to accurately analyze and assess your skincare needs.

Name:_____ Date:_____

Address:_____ City:_____ Province:_____ Postal Code:_____

Home Phone:_____ Business Phone:_____ Cell Phone:_____

Date of Birth:_____ Email address:_____

Emergency Contact:_____

Health History

What type of work do you do?_____ Have you seen a Dermatologist in the past year? ☐ Yes ☐ No

If yes, list Dermatologists name, contact information, and the reason for the visit: _____

Are you presently under the care of a physician? ☐ Yes ☐ No

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list all medications, including vitamins and herbal supplements:

_____

Please rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Please rate your stress level from 1-5 (5 being the highest) _____

Please check the following conditions you have or have experienced:

☐ Hypertension	☐ Headaches	☐ Eating Disorders
☐ Cold Sores	☐ Metal Plates	☐ Asthma
☐ Anemia	☐ Hernia	☐ Diabetes, Type:_____
☐ Cancer, Type:_____	☐ Lupus	☐ Stroke
☐ Seizures	☐ Thyroid Disease	☐ Irregular Pulse
☐ High Cholesterol	☐ Contact Lenses	☐ Tooth Fillings
☐ Heart Attack	☐ Claustrophobia	☐ High Blood Pressure
☐ Hepatitis, Type:_____	☐ Varicose Veins	☐ Low Blood Pressure
☐ Fainting	☐ Epilepsy	

Do you take natural supplements? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No Do you have a tendency to scar? ☐ Yes ☐ No

Allergies:

Check if you have you ever had an allergic reaction to any of the following:

☐ Aspirin or Salicylates	☐ Apples	☐ Ingredients in skincare products
☐ Milk	☐ Citrus	☐ Fish, marine or iodine allergies
☐ Peanuts or Tree Nuts	☐ Grapes	☐ Latex

If checked yes to any of the above, please explain: _____

Please list any other known allergies: _____

Have you ever had Herpes Simplex? ☐ Yes ☐ No

If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax® (Acyclivor), or Abreva®? ☐ Yes ☐ No

Female Clients:

Are you on hormone replacement therapy? ☐ Yes ☐ No

Are you presently taking or use any form of birth control (oral contraceptives, IUD, Depo-Provera, etc.)?_____

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Are you presently having any type of skin treatment? ☐ Yes ☐ No If yes, please list the type of treatment:_____

Do you have or have you had any of the following conditions:

☐ Skin Cancer ☐ Treatment Reactions ☐ Acne
☐ Broken Capillaries ☐ Keloid Scarring ☐ Hyperpigmentation
☐ Dermatitis ☐ Hypopigmentation ☐ Rosacea

Do you have or have you had any of the following treatments in the last 14 days?

☐ Facial Cosmetic Surgery ☐ Permanent Cosmetics ☐ Microdermabrasion
☐ Chemical Exfoliation (Peels) ☐ Light Treatments ☐ Hair Treatments (perm, colour, etc.)
☐ Botox Injections ☐ Waxing ☐ Other:_____
☐ Extractions ☐ Laser Resurfacing
☐ Fillers ☐ Laser Hair Removal

Home Care:

What skincare products are you currently using at home?

☐ Cleanser ☐ Exfoliants/Scrubs ☐ SPF
☐ Vitamin C ☐ Moisturize ☐ Mask
☐ Toner ☐ Specialty Products

Please check if you are presently using any of the following:

☐ Benzoyl Peroxide (BP) ☐ Resorcinol ☐ Vitamin A
☐ Glycolic Acid (AHA) ☐ Salicylic Acid (BHA) ☐ Hydroquinone (HQ)
☐ Lactic Acid (AHA) ☐ Sulfur
☐ Vitamin C ☐ Hydrocortisone (HC)

Prescription Products:

☐ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita) ☐ Azelaic Acid (Azelex®, Finacea™) ☐ Metrogel
☐ Isotretinoin (Accutane)
☐ Adepalene (Differin®) ☐ Triluma ™

Sun Protection:

Do you use a sunscreen? ☐ Yes ☐ No If yes, what level of protection? _____

Do you sunbathe or participate in outdoor activities? ☐ Yes ☐ No Do you tan in a tanning booth? ☐ Yes ☐ No

Have you tanned in a tanning booth in the last 14 days? ☐ Yes ☐ No

Have you had direct sun exposure in the last 10 days? ☐ Yes ☐ No

When exposed to the sun do you:

☐ Always burn, never tan ☐ Always burn, sometimes tan ☐ Sometimes burn, sometimes tan ☐ Always tan

Do you feel your skin is sensitive? ☐ Yes ☐ No

What skin conditions would you like to improve?

☐ Acne or Breakouts ☐ Hyperpigmentation (freckles, age ☐ Oily Skin
☐ Rosacea ☐ Spots ☐ Fine Lines and Wrinkles
☐ Facial Scarring ☐ Uneven Texture ☐ Sun Damage
☐ Uneven Tone ☐ Hypopigmentation ☐ Other:_____

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Is there any other necessary information your Skincare Specialist should know before beginning your treatment? ☐ Yes ☐ No

If yes, please explain: _____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition (s). I understand that I am required to sign this waiver prior to every treatment provided, and to update the Skincare Specialist with ANY changes pertaining to the above questionnaire.

Client Signature:_____ Date:_____

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Client Signature:_____ Date:_____

Client Signature:_____ Date:_____

Client Signature:_____ Date:_____

☐ Please check if permission is granted for Lifepath Wellness to use pictures for marketing and training purposes; your name will remain anonymous.