truecolors
medispa

Skin Consultation Form

Name: _____ **Date of Birth:** _____

Date: _____

Address: _____

Email: _____

Home phone: _____ **Cell phone:** _____

Referred by: _____

Emergency contact name and phone number: _____

Would you like to be notified by email of spa specials, events and promotions? **Yes** **No**

Healthy History

Within the 1st year, have you been under a dermatologist's or other physician's care? **Yes** **No**

Please list any injuries, surgeries or health conditions: _____

Do you smoke? **Yes** **No** Do you wear contacts? **Yes** **No**

Are you diabetic? **Yes** **No** Do you use sun block? **Yes** **No**

Do you have metal implants, a pacemaker or body piercings? **Yes** **No**

Do you have any skin conditions on your face or body such as psoriasis or eczema? **Yes** **No**

If yes. please specify: _____

Have you ever had chemical peels, microdermabrasion. or any resurfacing treatments? **Yes** **No**

!f yes. please indicate when: _____

Do you have a tendency to redness? **Yes** **No**

Do you ever experience oily shine during the day? **Yes** **No**

Are you pregnant? **Yes** **No** If yes, which trimester? _____

Are you currently using blood thinners? **Yes** **No**

If yes. please list: _____

Please list any known allergies: _____

Please list any medications you are currently taking, including vitamins, supplements, etc.:

_____

What skin care products are you currently using? (please circle)

Soap	**Cleanser**	**Exfoliator**
Moisturizer	**Masque**	**Prescription products -**
Eye products	**Toner**	**please list:**