

**GENESIS SALON, DAY SPA, AND LASER CENTRE
MEDICAL HISTORY AND SKIN CARE FORM**

NAME _____ DOB _____ DATE _____

PHONE: What is the best number for contacting you(H) _____ (C) _____

How did you hear about Genesis? _____

Who may we thank for referring you? _____

YOUR HEALTH

Allergies _____

Have you undergone any surgery within the last 6 months? Y N _____

Health conditions: (circle all that apply) Claustrophobia Diabetes Irregular Heart beat Heart Disease
High/Low Blood Pressure Pacemaker Fever blisters/Cold Sores Auto Immune Disorder

Medications (include ALL over the counter supplements and aspirin) _____

Natural hair color: Blonde Red Light Brown Brown Dark Brown Black Gray

Eye Color: Blue Green Hazel Brown Black

Do you smoke? Y N Are you Pregnant or lactating? Y N

Do you wear contact lenses? Y N Rate your stress level (1-Low, 2-High) 1 2 3 4

YOUR SKIN

Skin Tone (circle all that apply): Light European Native American Hispanic Asian African-American

What is your specific concern with your skin? (please circle all that apply)

| | | | | |
|--------------|----------------|---------------------|---------------|--------------|
| White heads | Blackheads | Acne | Excessive oil | Other (list) |
| Pigmentation | Sensitivities | Visible capillaries | Rosacea | _____ |
| Skin lesions | Dry/Dehydrated | Wrinkles | Fine Lines | _____ |

What Facial Skin care products are you currently using? List the brand you use.

Cleanser _____ Soap _____

Toner _____ Sunless tanners _____

Moisturizer _____ Specialty Products _____

Masque _____

EXFOLIATION HISTORY

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? Y N

If so, how long ago? _____

Do you (or have you ever) use Accutane, Retin A, Renova, Adapalene, Differen or any other prescription skin products? Currently Previously How long ago? _____

Are you currently using any products that contain the following ingredients? Please list brand used.

Glycolic Acid _____ Salicylic Acid _____

Lactic Acid _____ Any exfoliating scrubs _____

Vitamin A derivatives (i.e. retinol) _____

CAPILLARY ACTIVITY

Do you burn easily in moderate sunlight? Y N Do you blush easily when nervous? Y N

Do you have a tendency to redness? Y N Do you suffer from sinus problems? Y N

OIL SECRETION/MOISTURE/HYDRATION

Do you ever experience shine during the day? Y N Do you experience skin breakouts? Y N

of caffeinated beverages daily? (coffee, tea, soda) 1 2 3 4 5+

NERVE ACTIVITY

Do you ever experience a burning, itching sensation on your skin? Y N

Have you ever had a reaction to any of the following? (circle) Cosmetics Medicine Pollen Aspirin

Strawberries Milk Hydroxy acids Animals Fragrance Sunscreens

What type of massage pressure do you prefer? Light Medium Firm

WHAT ARE YOUR SKIN CARE GOALS? _____

Signature _____

Aesthetician Notes _____

_____ Initials _____

Name: _____ Referred by: _____
Personal: _____
Date: _____ Skin Condition: _____
Exfoliation: _____ Extractions: Y N
Masque: _____ Massage: Arms Chest Neck Face Ear Scalp Feet
Samples: _____
Plan: _____ Initials _____
Comments: _____

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