The Day Spa

Skin Consent Form

Full Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Email _____ Home Phone _____ Work Phone _____

Gender: ☐ Male ☐ Female Occupation _____

Pls select your preferred method of communication for future appointment confirmation:

☐ Phone Call ☐ Email ☐ Text

How did you hear about us? (If referred by someone, please list name) _____

HEALTH HISTORY

Have you been to a dermatologist within the last year? ☐ Yes ☐ No Reason for visit _____

Are you presently under a Physician's care? ☐ Yes ☐ No Reason for visit _____

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list _____

How would you rate your general skin health? Excellent _____ Good _____ Fair _____ Poor _____

Please rate your stress level from 1-5 (5 being the highest) 1 2 3 4 5

Have you experienced or have any of the following?

☐ Hypertension ☐ Hernia ☐ Stroke ☐ Epilepsy ☐ Diabetes ☐ Cold sores

☐ Lupus ☐ Hepatitis ☐ Contacts ☐ Headache ☐ Anemia ☐ Thyroid Disorder

☐ Irregular pulse ☐ Varicose veins ☐ Fainting ☐ Cancer ☐ Asthma ☐ Heart attack

☐ High cholesterol ☐ Metal Plates/Implants ☐ Seizures ☐ Eating disorder

☐ High/low Blood pressure

Do you take nutritional supplements? ☐ Yes ☐ No If so, what? _____

Do you exercise? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No Do you have tendency to scar? ☐ Yes ☐ No

ALLERGIES

Have you ever had an allergies reaction to any of the following?

Aspirin or Salicylates ☐ Yes ☐ No Fish, marine or iodine ☐ Yes ☐ No

Latex ☐ Yes ☐ No Apples ☐ Yes ☐ No Citrus ☐ Yes ☐ No

Grapes ☐ Yes ☐ No Specific Ingredients in skincare products _____

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

Are you being treated for Hepatitis? ☐ Yes ☐ No

Are you on hormone replacement therapy? ☐ Yes ☐ No If so, please list _____

Are you presently taking birth control? ☐ Yes ☐ No Please choose ☐ Pill ☐ IUD Other _____

Brand _____

SKIN CARE HISTORY

Home Care

What skincare products are you currently using at home?

Cleanser _____ Moisturizer _____ Serum _____

SPF _____ Toner _____ Exfoliant _____

Mask _____ Other _____

Please check if you take or use any of these:

Benzoyl Peroxide	☐ Yes	☐ No	Sulfur	☐ Yes	☐ No	Glycolic Acid	☐ Yes	☐ No
Vitamin A	☐ Yes	☐ No	Lactic Acid	☐ Yes	☐ No	Vitamin C	☐ Yes	☐ No
Salicylic Acid	☐ Yes	☐ No	Hydrocortisone	☐ Yes	☐ No			
Resorcinol	☐ Yes	☐ No	Hydroquinone	☐ Yes	☐ No			

Please check any prescriptions you take:

Tretinoin (Retin-A, Micro, Renova, Avita) ☐ Yes ☐ No Tazarotine (Tazorac) ☐ Yes ☐ No

Metrogel ☐ Yes ☐ No Adepalene (Differin) ☐ Yes ☐ No

Isotretinoin (Accutane) ☐ Yes ☐ No Azelaic Acid (Azelex, Finacea) ☐ Yes ☐ No

Triluma ☐ Yes ☐ No Any other topical antibiotics? _____

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

Chemical exfoliation (Peel)	☐ Yes	☐ No	Fillers	☐ Yes	☐ No
Laser Resurfacing	☐ Yes	☐ No	Botox Injection	☐ Yes	☐ No
Microdermabrasion	☐ Yes	☐ No	Collagen Injections	☐ Yes	☐ No
Light Treatment	☐ Yes	☐ No	Waxing	☐ Yes	☐ No
Permanent Cosmetics	☐ Yes	☐ No	Laser hair removal	☐ Yes	☐ No

Do you use sunscreen daily? ☐ Yes ☐ No Level of protections? SPF _____

Do you sunbathe or participate in outdoor activities? ☐ Yes ☐ No

Do you use a tanning bed? ☐ Yes ☐ No

If Yes, have you tanned in the last 14 days? ☐ Yes ☐ No

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

When exposed to the sun do you:

☐ Always Burn ☐ Usually Burn ☐ Rarely Burn ☐ Never Burn

Do you feel your skin sensitive? ☐ Yes ☐ No

When exposed to the sun do you tend to have:

Acne and/or breakouts	☐ Yes	☐ No	Enlarged Pores	☐ Yes	☐ No
Fine Lines / Wrinkles	☐ Yes	☐ No	Rosacea	☐ Yes	☐ No
Facial Scarring	☐ Yes	☐ No	Oily control	☐ Yes	☐ No
Uneven tone	☐ Yes	☐ No	Hypopigmentation	☐ Yes	☐ No
Uneven texture	☐ Yes	☐ No	Other	_____	

Is there any other necessary information your licensed Esthetician should know before beginning your treatment?

☐ Yes ☐ No If yes, please explain _____

My main skin concern is _____

☐ I acknowledge 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 desired results. Results cannot be guaranteed due to individual skin type(s) and condition(s). I agree to inform my technician to any changes pertaining to the above questionnaire. I further agree to all post-care instructions as I am directed.

Signature: _____ Date: _____