

Love Bella

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

Date _____ Name _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Home Phone(____) _____ Work Phone (____) _____ Cell (____) _____

MEDICAL INFORMATION

Date of Birth: _____ Age: _____ Family Physician _____ Do you smoke? _____ How often? _____ Live with a Smoker? _____
Have you ever been treated for: (please circle)
Acne Depression Skin Disease High Blood Pressure Cold Sores Diabetes Cancer
List all allergies/allergic: _____
List all medications that you are currently taking: _____
Are you pregnant? _____ Trying to get pregnant? _____ Hormone therapy? _____ Are you prone to cold sores? _____

PERSONAL INFORMATION

Circle your **current** level of stress: 1 2 3 4 5 6 7 8 9 10
Circle your **normal** level of stress: 1 2 3 4 5 6 7 8 9 10
How many ounces of Water do you drink daily? _____ Do you take supplements/Vitamins? _____
Do you exercise? ___ If so, how often: _____ your last sunburn? _____ Do you use tanning beds? _____
When you go out into the sun, do you (circle one):
Always Burn (I) Usually Burn (II) Sometimes Burn(III) Rarely Burn (IV) Very Rarely Burn (V) Never Burn (VI)
Have you ever been under the treatment plan of a:
Dermatologist ___ Plastic Surgeon ___ Esthetician ___ Would you be interested in cosmetic Surgery? ___ If yes, what procedure? _____
What skin line are you currently using? _____
Do you use a daily environmental protection product (sunblock)? _____ If not, why? _____
Circle how you feel about the **overall quality** of your skin:
1 (bad) 2 3 4 5 6 7 8 9 10 (fantastic)
Your skin type is?(please circle ONLY one):
Normal Dry/Dehydrated Oily Acne/Acne Prone Rosacea
In order of importance, please rank **1-most important** to 5-least important improvement in the next 30 days?
____ Reduction of fine lines
____ Reduction of brown spots/Sun Damage
____ Reduction of oil/acne
____ Acne scars diminished
____ Reduction of Redness

TREATMENT PLAN (To be completed by Physician/Esthetician)

1. Cleanse _____ 1. Cleanse _____
2. Anti-Age _____ 2. Anti-Age _____
3. Protect _____ 3. Repair _____
 Masque: _____
 Eye Treatment _____
 Bleaching _____

Professional Treatment Recommendation

- Chemical Peel
- Microdermabrasion
- Dual Peel

THANK YOU...for completing this confidential questionnaire.

Signature: _____ Date: _____

