The Spa at WDC
Cosmetic Skin Consult

Name: _____ Date: _____

Birth date: _____ Address: _____ State: ____ Zip: _____

Phone (H): _____ (W) _____ (Cell) _____

E-mail address: _____

How did you hear about us? _____

Have you been diagnosed with any skin conditions?
Rosacea? YES / NO
Acne YES/ NO
Other? _____

Current Medications: _____
_____

Medication Allergy: _____

Plant / Food Allergy: _____

Previous Cosmetic Procedures & Date of last treatment: _____
_____

MEDICAL HISTORY

Do you have a history of any of the following?

Accutane Use	Yes	No	Dates:
X-Ray treatment to face			Dates
Contact lens use			
Herpes Simplex/Cold sore			Medication used:
Diabetes			
Hepatitis			
Hypertension			
Pacemaker			
HIV/AIDS			
IUD			
Metal pins/plates			Location
Keloids/thick scars			
Currently smoke			
Alcohol use			

Developed: 6/05
Reviewed:

History of skin cancer			Type
Are you pregnant/lactating			
Birth control method			
Regular menstrual periods			
Menopausal/post-menopausal			

TANNING HISTORY:

Do you tan outdoors or with use of tanning bed? Yes/No

Do you use sunscreen regularly? Yes/No

SPF: _____ (zinc oxide, titanium dioxide, Parsol?)

SKIN TYPE

I	II	III	IV	V
Always Burns	Usually Burns	Sometimes Burns	Rarely Burns	Never Burns
Never Tans	Rarely Tans	Sometimes Tans	Tans Easily	Always Tans

Sensitive Skin? YES / NO If yes to what? _____

Are you: DRY / OILY / COMBINATION

SKIN CARE HISTORY

Use	Yes/No	Frequency
Cleanser		
Tone/astringent		
Moisturizer		
Nightly treatment		
Alpha Hydroxy, Salicylic Acid, Benzoyl Peroxide, vitamin C		
Retin A, Renova, Avage, or other prescription topical		

What are your concerns with your skin? _____