| Original Date: |
| --- |
| Dates Revised: |

# BELL'ADESSO CONFIDENTIAL SKIN HEALTH SURVEY

All questions contained in this questionnaire are strictly confidential. Please Print.

| | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name (Last, First, M.I.): | | ¨ M ¨ F | | DOB: | | | |
| Street: | | Appt: | | City: | | Zip: | |
| Phone: | ( ) | Alternate Number: | | ( ) | | | |
| Physician/Dermatologist: | | | Phone: ( ) | | | | |
| Emergency contact: | | | Phone: ( ) | | | | |
| Your occupation: | | | Referred by: | | | | |

## HISTORY

| | | | |
| --- | --- | --- | --- |
| 1. Have you ever had a blood transfusion? | | ¨ Yes | ¨ No |
| 2. What brings you in today? | | | |
| 3. What special areas of concern do you have? | | | |
| | | | |
| | | | |
| 4. Are you presently under a physician's care for any current skin condition or other problem? | | ¨ Yes | ¨ No |
| What condition? | | | |
| 5. Are you pregnant? | | ¨ Yes | ¨ No |
| 6. Are you taking birth control pills? | | ¨ Yes | ¨ No |
| If so, what type? | | | |
| 7. Hormone replacement | | ¨ Yes | ¨ No |
| 8. Do you wear contact lenses? | | ¨ Yes | ¨ No |
| 9. Do you smoke? | | ¨ Yes | ¨ No |
| 10. Do you often experience stress? | | ¨ Yes | ¨ No |
| 11. Have you had skin cancer? | | ¨ Yes | ¨ No |
| 12. Are you know using (or used in the past): | Azelex | ¨ Yes | ¨ No |
| | Differin | ¨ Yes | ¨ No |
| | Renova | ¨ Yes | ¨ No |
| | Retin-A | ¨ Yes | ¨ No |
| | Tazarac | ¨ Yes | ¨ No |
| | Glycolic or alphahydroxy acids? | ¨ Yes | ¨ No |
| 13. Are you now using or have you ever used Accutane? | | ¨ Yes | ¨ No |
| If so, when and how long? | | | |
| 14. Do you have acne? | | ¨ Yes | ¨ No |
| Experience frequent blemishes? | | ¨ Yes | ¨ No |
| How frequently? | | | |

| | | | | | |
|---|---|---|---|---|---|
| 15. Do you have any allergies to cosmetics, foods or drugs? | | | | ¨ Yes | ¨ No |
| Please list: | | | | | |
| 16. Are you presently taking medications - oral or topical? | | | | ¨ Yes | ¨ No |
| Please list: | | | | | |
| 17. What products do you use presently? | Soap | | | ¨ Yes | ¨ No |
| | Cleansing Milk | | | ¨ Yes | ¨ No |
| | Toner | | | ¨ Yes | ¨ No |
| | Scrub | | | ¨ Yes | ¨ No |
| | Mask | | | ¨ Yes | ¨ No |
| | Creams | | | ¨ Yes | ¨ No |
| | Sunscreen | | | ¨ Yes | ¨ No |
| | Other | | | ¨ Yes | ¨ No |

Please check if you are affected by or have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| ¨ | Asthma | ¨ | Hepatitis | ¨ | Metal bone, pins, or plates |
| ¨ | Cardiac problems | ¨ | Herpes | ¨ | Pacemaker |
| ¨ | Eczema | ¨ | High blood pressure | ¨ | Psychological problems |
| ¨ | Epilepsy | ¨ | Hysterectomy | ¨ | Sinus problems |
| ¨ | Fever blisters | ¨ | Immune disorders | ¨ | Skin diseases-other |
| ¨ | Headaches-chronic | ¨ | Lupus | ¨ | Urinary or kidney problems |

Please explain above or list any significant others:

I understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purposes or and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Spa Policies

1. Professional consultation is required before initial dispensing of products.
2. We require a 24-hour cancellation notice.

I fully understand and agree to the above spa policies.

| | | | |
|---|---|---|---|
| Client's signature: | | Date: | |