SKIN CARE HISTORY QUESTIONNAIRE

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin care needs.

Date_____/_____/_____

Name (please print clearly) Date of Birth_____/_____/_____

First_____ Last_____ M.I._____

Street Address_____ City_____ State_____ Zip_____

Phone_____ E-Mail Address_____

Please check if presently using any of the following? (Please ✓ all that apply.)

❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid ❑ Hydroquinone ❑Topical Vitamin C

❑ Prescription strength topical steroids- Retinoid (Vit. A derivatives), Retin-A, Tazorac, Renova, Differin

Which conditions do you want to improve? (Please ✓ all that apply.)

❑ Hyperpigmentation (Brown Spots) ❑ Acne/Acne Scarring ❑ Sun Damage ❑ Enlarged Pores

❑ Fine Lines & Wrinkles ❑ Surgical Facial Scars ❑ Age Spots ❑ Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No

FEMALE CLIENTS

Are you on hormone replacement therapy? ❑ Yes ❑ No

Are you presently taking birth control pills? ❑ Yes ❑ No

Are you pregnant or planning to be? ❑ Yes ❑ No

ALL CLIENTS

Do you use sunscreen/sun block? ❑ Yes ❑ No

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

Do you have or have ever had acne? ❑ Yes ❑ No

Are you using or have ever used any medications for acne? ❑ Yes ❑ No

Name of medications _____

Have you seen a Dermatologist in the past year? ❑ Yes ❑ No

If yes, list doctors name and reason for visit_____

_____

Are you presently under a doctor's care? ❑ Yes ❑ No

What medications do you take on a regular basis? _____

_____

Have you ever had Herpes (cold sores)? ❑ Yes ❑ No

Have you ever been treated with Zovirax or any medication for herpes? ❑ Yes ❑ No

Do you have Epilepsy, Diabetes, or other auto-immune disorders? ❑ Yes ❑ No

If yes, you will be treated only with a doctor's release!

Are you presently under a physician's care for any reason? ❑ Yes ❑ No

Explain _____

Do you use Bioré or snore strips? ❑ Yes ❑ No

Have you had any of the following? ❑ Yes ❑ No (Please ✓ all that apply.)

❑ Cosmetic Surgery ❑ Laser Resurfacing/IPL ❑ Botox Injections ❑ Chemical Peels ❑ Skin Cancer

❑ Hepatitis ❑ Dermatitis ❑ Keloid Scarring ❑ Dermal Fillers ❑ Other (Specify) _____

Are you allergic to Iodine or Seaweed?	❑ Yes	❑ No
Are you allergic to aspirin?	❑ Yes	❑ No
Do you have any other allergies?	❑ Yes	❑ No

If yes, list: _____

Do you smoke?	❑ Yes	❑ No
Do you take nutritional supplements?	❑ Yes	❑ No
Are you on a diet?	❑ Yes	❑ No
Do you exercise?	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No
Have you had skin treatments (facials) before?	❑ Yes	❑ No
Are you currently having facials?	❑ Yes	❑ No
Have you had electrolysis or waxing in the past week?	❑ Yes	❑ No
Do you have those services done?	❑ Yes	❑ No
Have you had permanent cosmetics?	❑ Yes	❑ No

If yes, where? _____

How is your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

If poor, explain: _____

What skin care products are you currently using?_____

_____

What about your skin you would like to change? _____

_____

Is there any other information I should know before beginning your treatment? _____

_____

RADIO FREQUENCY INFORMED CONSENT

Hi.LDM Perfect is a multi-purpose radio frequency and high focused ultrasound device for treatment of wrinkles and skin tightening.

I understand the results may vary person-to-person and 4-6 treatments spaced out 14 days is recommended to achieve the optimal results. As an exact result cannot be predicted, I acknowledge that no guaranties have been made.

Side effects are rare and can include swelling, minor bumps, and flushed skin.

I confirm that I don't have a pacemaker, internal defibrillator, pregnant, or breast feeding. I do not have a history of epilepsy. I have had the opportunity to ask questions, and these questions have been answered to my full satisfaction.

I have read this entire document.

Client Signature_____**Date**_____