GENESIS SALON, DAY SPA, AND LASER CENTRE
MEDICAL HISTORY AND SKIN CARE FORM

NAME_____DOB_____ DATE_____
PHONE: What is the best number for contacting you(H)_____(C)_____
How did you hear about Genesis?_____
Who may we thank for referring you?_____

YOUR HEALTH

Allergies_____
Have you undergone any surgery within the last 6 months? Y N _____
Health conditions: (circle all that apply) Claustrophobia Diabetes Irregular Heart beat Heart Disease
High/Low Blood Pressure Pacemaker Fever blisters/Cold Sores Auto Immune Disorder
Medications (include ALL over the counter supplements and aspirin)_____
_____
Natural hair color: Blonde Red Light Brown Brown Dark Brown Black Gray
Eye Color: Blue Green Hazel Brown Black
Do you smoke? Y N Are you Pregnant or lactating? Y N
Do you wear contact lenses? Y N Rate your stress level (1-Low, 2-High) 1 2 3 4

YOUR SKIN

Skin Tone (circle all that apply): Light European Native American Hispanic Asian African-American
What is your specific concern with your skin? (please circle all that apply)

White heads	Blackheads	Acne	Excessive oil	Other (list)
Pigmentation	Sensitivities	Visible capillaries	Rosacea	_____
Skin lesions	Dry/Dehydrated	Wrinkles	Fine Lines	_____

What Facial Skin care products are you currently using? List the brand you use.
Cleanser_____ Soap_____
Toner_____ Sunless tanners_____
Moisturizer_____ Specialty Products_____
Masque_____ _____

EXFOLIATION HISTORY

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? Y N
If so, how long ago?_____
Do you (or have you ever) use Accutane, Retin A, Renova, Adapalene, Differen or any other prescription skin products? Currently Previously How long ago?_____
Are you currently using any products that contain the following ingredients? Please list brand used.
Glycolic Acid _____ Salicylic Acid_____
Lactic Acid _____ Any exfoliating scrubs_____
Vitamin A derivatives (i.e. retinol)_____

CAPILLARY ACTIVITY

Do you burn easily in moderate sunlight? Y N Do you blush easily when nervous? Y N
Do you have a tendency to redness? Y N Do you suffer from sinus problems? Y N

OIL SECRETION/MOISTURE/HYDRATION

Do you ever experience shine during the day? Y N Do you experience skin breakouts? Y N
# of caffeinated beverages daily? (coffee, tea, soda) 1 2 3 4 5+

NERVE ACTIVITY

Do you ever exoerience a burning, itching sensation on your skin? Y N
Have you ever had a reaction to any of the following? (circle) Cosmetics Medicine Pollen Aspirin
Strawberries Milk Hydroxy acids Animals Fragrance Sunscreens
What type of massage pressure do you prefer? Light Medium Firm

WHAT ARE YOUR SKIN CARE GOALS?_____

Signature_____

Aesthetician Notes_____
_____
_____
_____Initials_____

Name:______________________________ Referred by:__________________________
Personal:____

Date:________ Skin Condition:____
Exfoliation:____ Extractions: Y N
Masque:________________________ Massage: Arms Chest Neck Face Ear Scalp Feet
Samples:____
Plan:____ Initials_____
Comments:____
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