Esthetic Skin Anaylysisian

Name _____ Phone _____ DOB _____

Address _____ City/State/Zip _____

Email _____ How did you hear about us? _____

The Basics:

Please mark any of the following you **have or have experienced.

- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Claustrophobia
- ☐ Cold Sores
- ☐ Contact Lenses
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irregular Pulse
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Phlebitis/ Varicose Veins
- ☐ Stroke
- ☐ Seizures
- ☐ Thyroid Disorders
- ☐ Tooth Fillings
- ☐ Others, please specify

Facial Surgery:

Have you had laser resurfacing or facial Plastic Surgery in the past 3 months? ☐ Yes ☐ No

Are you planning to have facial resurfacing soon? ☐ Yes ☐ No

Are you planning to have eyelid surgery soon? ☐ Yes ☐ No

Are you planning to have other facial Plastic Surgery soon? ☐ Yes ☐ No

In the past 14 days have you had any chemical peels or waxing done? ☐ Yes ☐ No

Lifestyle:

Do you wear glasses? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you ever had an allergic reaction to any of the following? (Check all that apply)

- ☐ Aspirin
- ☐ Apples
- ☐ Citrus
- ☐ Clindamycin
- ☐ Cosmetics
- ☐ Fish
- ☐ Fragrances
- ☐ Grapes
- ☐ Hydrogen Peroxide
- ☐ Hydroquinone
- ☐ Iodine
- ☐ Latex
- ☐ Milk
- ☐ Retin-A
- ☐ Talc
- ☐ No allergies to any of the above
- ☐ Others, please specify

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

Do you currently take any antioxidant supplements? ☐ Yes ☐ No

Do you use Retin-A? ☐ Yes ☐ No If yes, what for? ☐ Acne ☐ Fine Lines

Do you have irritation or sensitivity from using Retin-A? ☐ Yes ☐ No

Have you ever used the acne drug Accutane? ☐ Yes ☐ No If yes, how long ago? _____

Are you currently on a restricted diet? ☐ Yes ☐ No

What water temperature do you cleanse with? ☐ Cool ☐ Warm ☐ Hot

How would you describe your skin type? (select one)

Dry Normal to Dry Normal Normal to oily Oily

Which of the following most closely describes your skin type?

- Very Fair skin tone, freckles, burns easily, never tans
- Light skin tone, will tan but usually burns
- Light to olive skin tone, sometimes burns
- Medium brown skin tone, rarely butns
- Dark brown skin tone very rarely burns
- Dark skin tone, burn-resistant

When you are in the sun for extended periods, do you use a sunscreen/sunblock? Yes No

Do you have any special skin problems? (Check all that apply)

- Adolescent Acne eruptions
- Adult onset Acne
- Deep cystic Acne
- Oily skin, but no eruptions
- Dry skin with acne outbreaks
- Lines and wrinkles from sun damage (photo-aging)
- Combination skin (dry in some places, oily in the T zone)
- Hyperpigmentation (brown spots on the skin)
- Acne scarring
- Enlarged pores
- I have no special

Does your skin have dry patches? No Occasionally Frequently

Is your skin extremely dry? Yes No

Oil Secretion: What time of day do you first notice oil?

- 15 to 30 minutes after cleansing
- Lunch time (12pm)
- Late Day 4pm - 5pm
- I do not experience oily shine during the day
- Midmorning 9am-10am
- Mid-afternoon 2pm-3pm
- Totally Dry

Do you experience skin break-outs? Yes No

Do you have blackheads? Few or none Some, especially in the T-zone Problem

Your pore size: Enlarged all over Some, enlarged in the T-zone Nearly invisible

Your skin texture is: Bumpy and uneven Smooth and soft Coarse and grainy

Skin thickness: Thick Normal Thin

Facial Lines: a few or none Some around the eyes Around eyes and on face Around the lip area

Do you have eye area puffiness? No Occasionally Frequently

Do you have dark under eye shadows Seldom Occasionally Frequently

Capillary Activity: Do you have a tendency to redness in skin tone? Yes No

Do you have small, red broken capillaries that show through your foundation?

Problem (nose/cheeks/chin) Few None

Your current skin products:

What types of cleaners are you now using? Soap Cleanser Lotion Cream

Are you currently using bar soap to cleanse your face? Yes No

Do you use skin care products that contain mineral oil, lanolin, alcohol, color, fragrance, or formaldehyde? Yes No

What product line are you currently using?

Have you used glycolic? Yes No Unsure If so, what percentage?

Are you susceptible to cold sores? Yes No
Are you being treated for Herpes and/or Hepatitis? Yes No
Are you on hormone replacement therapy? Yes No
Women Only: Are you taking oral contraception? Yes No
Are you pregnant, trying to become pregnant, or breastfeeding? Yes No
Men Only: Do you ever experience irritation from shaving? Yes No
Do you experience ingrown hairs? Yes No

Are you on any medication? Yes No If yes, which ones _____

Do you exercise? Yes No If yes, how many times per week ? ____ How many hours?_____

Moisture Hydration: How much plain water do you consume daily?

1-2 cups 3-4 cups 5-6 cups 7+ cups

Please choose up to three skin care issues that you would like help with.

- Clear up acne eruptions
- Clear up blackheads
- Minimize the size of pores
- Decrease oiliness of the skin
- Diminish the appearance of capillaries on the face
- Lighten skin complexion or hyperpigmentation areas
- Restore skin elasticity
- Hydrate the skin
- Smooth skin texture
- Diminish flakiness of skin
- Lighten acne scarring
- Diminish wrinkles/ fine lines
- Pre-facial surgery skin preparation
- Post-facial surgery skin care

By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form accurately to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Signature _____