



Please complete the brief survey below to help us better serve your needs. Thank you.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**SKIN TYPE:**

- Normal
- Dry
- Oily
- Sensitive

**SKIN CONCERNS:**

- Acne
- Fine Lines / Wrinkles
- Sun Damaged Skin
- Acne Scarring
- Deep Wrinkles
- Facial or Excessive Body Hair
- Pigmentation / Spots
- Skin Tone / Texture
- Cellulite
- Spider Veins
- Enlarged Pores
- Aging

**SKIN HISTORY:**

- Rosacea
- Eczema
- Psoriasis
- Accutane Use / Dates Used \_\_\_\_\_
- Fever Blisters
- Skin Cancer / Date \_\_\_\_\_

**CURRENT SKIN CARE PRODUCTS USED:**

PRODUCT	MORNING	EVENING

Please list all medications, topical creams and herbal supplements that you use: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_