CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

DATE ______
NAME ______
ADDRESS ______
CITY/STATE/ZIP ______
HOME PHONE ______
WORK PHONE ______
CELL ______
EMAIL ______
OCCUPATION ______
REFERRED BY ______

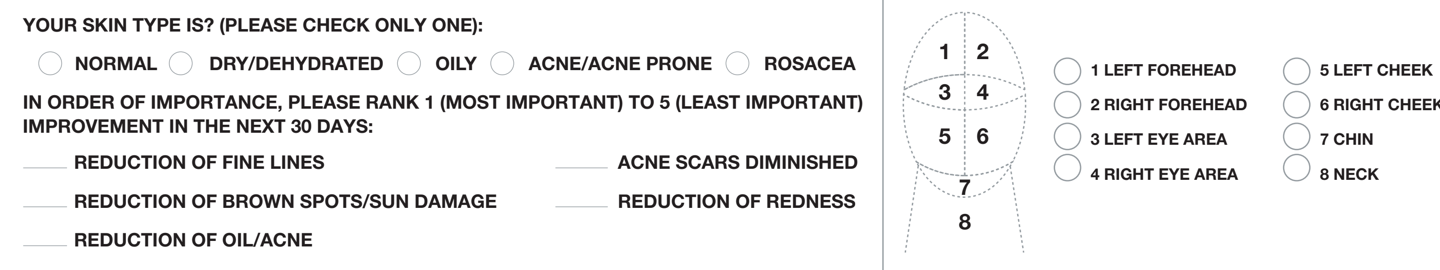
DATE OF BIRTH ______ AGE ______ FAMILY PHYSICIAN ______
DO YOU SMOKE? ______ HOW OFTEN? ______ LIVING WITH A SMOKER? ______
HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)
- ◯ ACNE ◯ DEPRESSION ◯ SKIN DISEASE ◯ HIGH BLOOD PRESSURE
- ◯ COLD SORES ◯ DIABETES ◯ CANCER

LIST OF ALL ALLERGIES ______
LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING ______
ARE YOU PREGNANT? ______ TRYING TO GET PREGNANT? ______ HORMONE THERAPY? ______
ARE YOU PRONE TO COLD SORES? ______

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? ______ DO YOU TAKE SUPPLEMENTS/VITAMINS? ______
DO YOU EXERCISE? ______ IF SO, HOW OFTEN: ______ YOUR LAST SUNBURN? ______ DO YOU USE TANNING BEDS? ______
WHEN YOU GO OUT INTO THE SUN, DO YOU (CHECK ONE):
◯ ALWAYS BURN (I) ◯ USUALLY BURN (II) ◯ SOMETIMES BURN (III) ◯ RARELY BURN (IV) ◯ VERY RARELY BURN (V) ◯ NEVER BURN (VI)
HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:
◯ DERMATOLOGIST ◯ PLASTIC SURGEON ◯ AESTHETICIAN ◯ WOULD YOU BE INTERESTED IN COSMETIC SURGERY? ______
IF YES, WHAT PROCEDURE? ______

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)
◯ SUN SPOTS ◯ SKIN LAXITY ◯ DRY / ROUGH
WHAT SKIN LINE ARE YOU CURRENTLY USING? ______
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? ______ IF NOT, WHY? ______
CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)



YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):
◯ NORMAL ◯ DRY/DEHYDRATED ◯ OILY ◯ ACNE/ACNE PRONE ◯ ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:
- ____ REDUCTION OF FINE LINES
- ____ ACNE SCARS DIMINISHED
- ____ REDUCTION OF BROWN SPOTS/SUN DAMAGE
- ____ REDUCTION OF REDNESS
- ____ REDUCTION OF OIL/ACNE

◯ 1 LEFT FOREHEAD ◯ 5 LEFT CHEEK
◯ 2 RIGHT FOREHEAD ◯ 6 RIGHT CHEEK
◯ 3 LEFT EYE AREA ◯ 7 CHIN
◯ 4 RIGHT EYE AREA ◯ 8 NECK

TREATMENT PLAN

PROFESSIONAL TREATMENT RECOMMENDATION

- ◯ I PEEL ormedic lift™
- ◯ I PEEL lightening lift® *FORTE*
- ◯ I PEEL acne lift®
- ◯ I PEEL perfection lift™ *FORTE*
- ◯ I PEEL the signature facelift®
- ◯ I PEEL wrinkle lift®
- ◯ I PEEL beta lift™
- ◯ O^2 lift®
- ◯ I PEEL lightening lift®
- ◯ I PEEL wrinkle lift® *FORTE*
- ◯ I PEEL perfection lift™
- ◯ IMAGE facial

Thank you for completing this confidential questionnaire. This information will allow your professional skincare specialist to provide the optimum IMAGE Skincare products and services.

SIGNATURE: ______ **DATE:** ______

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