Facial Consultation Form

Name: ______________________________ **Date of Birth:** _______________________

Home Phone: ________________________ **Cell Phone:** _________________________

Address______________________________ **City** _______________________ **Zip Code**__________

E-mail Address: ____

Medical History

Check Box Where Applicable / Fill in with Details

- ☐ Acne
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Control
- ☐ Blood Thinner
- ☐ Claustrophobia
- ☐ Contact Lens
- ☐ Diabetic
- ☐ Epilepsy
- ☐ Facial Implants
- ☐ Fever Blister
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Hormones
- ☐ Hyper/Hypo Thyroid
- ☐ Lupus
- ☐ Nail Disorders
- ☐ Permanent Make-up
- ☐ Pregnant
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seborrhea
- ☐ Sensitive Skin
- ☐ Sterioids
- ☐ Warts
- ☐ Differin
- ☐ Obagi System
- ☐ Retin-A
- ☐ Renova
- ☐ Vitamin A Products
- ☐ Accutane ________________
- ☐ Eczema ________________
- ☐ Prescription Face Creams ________________
- ☐ Skin Cancer ________________

Allergies: ____

Allergic to any essential oils: ____

What concerns do you have about your skin? ________________________________

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Facial Plastic Surgery: ____

Do You Smoke? ☐ **Yes** ☐ **No**

Release and Consent:

The above information is accurate to the best of my knowledge. I understand that the esthetician, while trained and licensed in esthetics, is not trained to diagnose or treat any form of illness, disease, or injury. I agree to tell the esthetician of any pain or unusual sensitivity I may experience during the facial. I understand it is my responsibility to inform the esthetician about any changes in my condition if I should decide to return for further facials.

Signature: ______________________________________ Date: _________________________