



Client Profile

Please answer all questions to the best of your ability. Please print clearly. You must fill out this form completely before your consultation.

Name: _____ Date: _____

DOB: _____

Address: _____

City: _____ State: _____ zipcode _____

Home Phone: () _____ Cell Phone: () _____

E-Mail: _____

Employer: _____ Occupation: _____

Business Phone: () _____

In case of emergency, please contact:

_____ Relation _____

Phone: () _____ Cell Phone: () _____

What cosmetic improvements you would like to see in your skin?

What skin treatments are you interested in? _____

How did you hear about us? _____

Lifestyle

Do you smoke cigarettes? Y or N How often? _____ Packs/day? _____

Do you drink alcohol? Y or N

How much per day? _____

Do you smoke marijuana or use other recreational drugs? Y or N

Do you exercise? Y or N

How often per week? _____

What is your water intake (glasses per day)? _____

How many hours do you sleep per night? _____

Stress Level: High _____ Medium _____ Low _____

Medical History

Please **check** if you have, or ever had any of the following:

Skin cancer, or pre-cancer___ HIV___ Herpes___ Lupus___
Hormonal Disorder___ Cold Sores___ Diabetes___ Irregular Periods___ Anemia___
Dermatitis___ Polycystic ovary syndrome___ Hepatitis___
Keloids___ Methemoglobinemia___ Jaundice___ Liver disease___
Abnormal blood pressure___ Heart disease___ Thyroid condition___
Epilepsy___ Psychiatric care___ Nervous disorder___
Is there any other information about your health that we should know?

Are you pregnant or breastfeeding? _____

List any other health or medical conditions you have: _____

Are you currently using any oral, injectable, or skin medications? Y or N
If so, please
list. _____

Have you ever had gold injections? Y or N

Are you allergic to latex? Y or N

Do you have any food or medicine allergies? Y or N

If so, please

list. _____

Are you taking Aspirin, Motrin, Aleve, OTC or prescription medications? Y or N

If so, please list: _____

Are you taking Accutane? Y or N

Have you taken Accutane in the last six months? Y or N

Side-Effects of Accutane?

Do you use Birth Control? Y or N

If so, please

list? _____

Skin History and Profile

Please **check** if you have any of the following skin conditions:

Oily___ Dry___ Sensitive___ Combination___ Keloids___

Cystic Acne___ Razor Bumps___ Dark Spots___ Sun Damage___

Scalp Problems___

Describe Your skin: _____

Age skin problem started? _____ Acne in family? _____

Do you pick at your skin lesions (i.e. Acne, razor bumps)? _____

What is your daily skin care regimen? What skin products are you using?

(i.e. Neutrogena): _____

Do you wear make-up? _____ What brand? _____

Have you ever had a bad reaction to a skin product or procedure? Y or N

If so, what happened? _____

Have You Received Treatment From a Medspa or Dermatologist? Y or N
If so, what treatment?

Have you tanned in the last 4 weeks? Y or N

Urban Skin Solutions, or any of their employees or agents, is not liable for damages resulting from conditions, facts, or circumstances not provided in response to the above questions.

Signature
Parent/Legal Guardian Signature(if under 18)

Date: _____