Aesthetic Surgical Arts
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Skin Enhancement Center Consultation

Name: _____ **Date:** _____

Medications: **Allergies:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

1. Have you taken any of these medications in the last six months?

Accutane	Yes	No	Blood Thinners	Yes	No
Retin-A	Yes	No	Gold Shots	Yes	No

2. Are currently:

Pregnant	Yes	No	Nursing	Yes	No

3. Check the boxes that apply:

☐ Casual Sun	☐ Low Stress Level	☐ Lack of Sleep
☐ Intense Sun	☐ Moderate Stress Level	☐ Poor Nutrition
☐ Smoking	☐ High Stress Level	☐ Illness
☐ Use of Tanning Booth	☐ Exercise Regularly	☐ Other

4. Check the boxes below which indicate your area(s) of concern:

☐ Fine Lines	☐ Uneven Texture	☐ Eye Puffiness
☐ Dark Spots	☐ Dullness	☐ Dark Circles
☐ Uneven Color	☐ Dehydration	☐ Loss of Firmness
☐ Broken Capillaries	☐ Large Pores	☐ Other

5. What is the goal for your facial treatment? (Check all that apply)

☐ Anti-Aging ☐ Improved Complexion ☐ Relaxation
☐ Other: _____
_____

6. Have you received treatments by an aesthetician before? ☐ Yes ☐ No

7. Current skin care program:

☐ **None**

Morning:			**Night:**		
Cleanse	☐ Yes	☐ No	**Cleanse**	☐ Yes	☐ No
Toner	☐ Yes	☐ No	**Toner**	☐ Yes	☐ No
Moisturizer	☐ Yes	☐ No	**Moisturizer**	☐ Yes	☐ No
Supplements	☐ Yes	☐ No	**Supplements**	☐ Yes	☐ No

Reviewed By: _____