Angelface Day Spa
Excellence In Esthetics

Facial

Skin Analysis and History Form

What is your skin type?	☐ Normal	☐ Oily	☐ Dry	☐ Combination
Your skin is...	☐ Resilient	☐ Sensitive	☐ Unknown	
Elasticity	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Acne Stage:	☐ I	☐ II	☐ III	☐ IV
Fine Lines: (Glogau Scale)	☐ Stage I - None	☐ Stage II - Wrinkles in Motion	☐ Stage III - Wrinkles at Rest	☐ Stage IV - Mostly Wrinkles

Check any of the following words or conditions which describe your skin:	☐ Thick	☐ Loose	☐ Wrinkled	☐ Sun-damaged
	☐ Thin	☐ Firm	☐ Acne-prone	☐ Freckled
	☐ Textured	☐ Uneven	☐ Cystic acne	☐ Rosacea
	☐ Milia	☐ Fine lines	☐ Sallow	☐ Psoriasis
	☐ Age spots	☐ Redness	☐ Dehydrated	☐ Large pores

How frequent is your sun exposure?	☐ Never	☐ Light	☐ Moderate	☐ Excessive
What type of foundation do you use?	☐ None	☐ Liquid	☐ Cream	☐ Powder
How does your skin heal?	☐ Fast	☐ Slow	☐ Scars	☐ Pigments
Do you bruise easily?	☐ Yes	☐ No		

What would you like to achieve from your treatment today? ____________________

____

Do you use any kind of acne medication? ☐ Yes ☐ No
If yes, please explain: ____________________

Do you use any prescription skin products, including Accutane or Retin-A? ☐ Yes ☐ No
If yes, please specify: ____________________

Have you had collagen, Botox, or other dermal filler injections within the last 6 months? ☐ Yes ☐ No
If yes, please explain: ____________________

Do you have any allergies? ☐ Yes ☐ No
If yes, please list: ____________________

Have you seen a dermatologist for anything in the past year? ☐ Yes ☐ No
If yes, please explain: ____________________

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Facial Intake Form

Name ______________________ Birthday ______________

Address: ______________________

City: ______________ State/Province: __________ Zip/Postal Code: ______________

Phone #______________ Email: ______________________

Emergency Contact Name & Number: ______________________

Would you like to be added to our email list for information and discounts? ☐ Yes ☐ No

How did you hear about us?______________________

Question		
Are you pregnant or nursing?	Y	N
Do you have diabetes?	Y	N
Do you have epilepsy?	Y	N
Do you have a cardiovascular and/or thyroid condition?	Y	N
Do you have trouble with wounds healing?	Y	N
Have you ever been diagnosed with Cancer?	Y	N
If yes, are you undergoing Cancer treatment?	Y	N
Do you have any skin conditions?	Y	N
Do you work outdoors?	Y	N
Do you wear contact lenses?	Y	N
Do you have a history of smoking/tobacco use?	Y	N
Do you exercise regularly?	Y	N
Do you use SPF on your face?	Y	N
Are you currently ill?	Y	N

Please list any other conditions, diseases, or disorders:______________________

____

Is there any additional information you would like to let your provider know? ______________________

____

With my signature below, I confirm that I have accurately completed the information above to the best of my knowledge. I agree to notify the provider of any other relevant information that may affect my procedure, including any changes to the information above. I release my provider of any and all liability of injury or damages that may arise because I have not represented my medical history accurately.

Printed Client's Name	Signature	Date
______________	______________	________
Provider's Name	**Signature**	**Date**
______________	______________	________