radiance medspa

Cosmetic Interest Questionnaire

Do you currently get/use: ☐Facials ☐Waxing ☐Electrolysis ☐ Depilatories
Describe type/frequency/reaction: _____
_____
Have you ever had microdermabrasion or chemical peels? **Y/N** Type_____ Frequency_____
Describe your reaction: _____
Have you ever had a dermal filler injection? **Y/N** When_____ Type_____
Describe your reaction: _____
Have you ever had Botox injections? **Y/N** When_____ Frequency _____
Describe your reaction: _____
Have you ever had laser resurfacing? **Y/N** When_____ Type_____ Depth_____
Describe your reaction: _____
Have you recently had facial or cosmetic surgery? **Y/N** When?_____
Describe: _____
Have you ever used any products that caused a bad reaction? **Y/N**
If yes, describe: _____
Have you ever seen a dermatologist or other physician for your skin? **Y/N**
If yes, describe: _____
Have you ever had a skin allergy or sensitivity? (rash, irritation, peeling, swelling, hives, etc?) **Y/N**
If yes, describe: _____

How would you describe your skin type? ☐ normal ☐ dry ☐ oily ☐ combination
Describe your ethnic background: _____
Do you redden easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? Y/N
How do you tan? ☐I always burn ☐II usually burn ☐III sometimes burn
☐IV rarely Burn ☐V never burn
Is your pigmentation/coloring ☐ even ☐uneven
Do you have broken capillaries? **Y/N**
If yes, Where? ☐ nose area ☐ cheek area ☐ chin area ☐ forehead ☐ entire face
Do you have a history of acne or breakouts? **Y/N** If yes, which of the following apply?
☐pimples ☐cysts ☐whiteheads ☐blackheads ☐acne scars ☐flakiness ☐enlarged pores

Does your skin appear fragile or burn easily? **Y/N** if yes, describe: _____
Do you have any problems healing from a cut or burn? **Y/N** if yes, describe:_____
Have you ever had a cold sore? **Y/N** If yes, describe:_____
Are you in the habit of visiting tanning booths? **Y/N** If yes, how often? _____
Do you currently use sun block regularly? **Y/N** Are you currently sunburned/wind burned? **Y/N**
Have you or anyone in your family had skin cancer? **Y/N** if yes, describe:_____

Describe your daily home care regimen: ☐ cleanser ☐ toner ☐moisturizer
☐ serums/treatment creams ☐exfoliants ☐ other_____
Current appearance problems/goals that brought you to Radiance Medspa:_____
_____
Appearance "wish list" (anything about your appearance that you wish you could change or improve): _____
_____

What skin conditions are you interested in improving? (check all that apply):

☐ fine lines	☐ laxity/loose skin	☐ broken capillaries	☐ discoloration
☐ spider veins	☐ sun damage	☐ unwanted hair	☐ cellulite
☐excess fat	☐ texture/pores	☐ redness/rosacea	☐ wrinkles ☐ acne