

FreshFaces

Name..... Tel. Home.....

Address..... Work.....

Post Code..... Mobile.....

Email..... Date of Birth.....

Occupation.....

How did you hear about FreshFaces.....

1. Have you been under a dermatologist in the last year?
2. Have you undergone surgery in the last year?
3. Are you on medication? Please State.....
4. Do you smoke?
5. Do you wear contact lenses?
6. Do you exercise regularly?
7. Do you have metal plates, pacemaker or body piercings?
8. Do you have;-
Diabetes.....Asthma.....Eczema.....Psoriasis.....Dermatitis.....Keloid scars.....
Skin Cancer.....Epilepsy.....Spinal injury.....Claustrophobia.....
9. Are you pregnant or trying to become pregnant or breast feeding?
10. Do you have any allergies? Aspirin?
11. What skin care products are you currently using? Please tick.
Soap....Cleanser....Toner....Moisturizer....mask....exfoliator....eye cream....
12. Have you ever had chemical peels or microdermabrasion?
13. Have you used, in the last 6 months, any products that contain;-
lactic acid....glycolic acid....salicylic acid....alpha hydroxyl acid....vitamin A
14. What is your daily intake of; - water.....alcohol.....tea.....coffee.....
15. Do you experience a burning itching sensation on your skin Yes No
16. Do you experience oily shine during the day? Yes No
17. Do you experience skin breakouts? Yes No
18. When did you last have a facial or
treatment?.....
19. What are your concerns and expectations and skin care goals
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Client's signature

Clients signature