IMAGE SKINCARE

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

DATE
NAME
ADDRESS
CITY/STATE/ZIP
HOME PHONE
WORK PHONE
CELL
EMAIL
OCCUPATION
REFERRED BY

MEDICAL INFORMATION

DATE OF BIRTH AGE FAMILY PHYSICIAN
DO YOU SMOKE? HOW OFTEN? LIVING WITH A SMOKER?
HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)
( ) ACNE ( ) DEPRESSION ( ) SKIN DISEASE ( ) HIGH BLOOD PRESSURE
( ) COLDSORES ( ) DIABETES ( ) CANCER
LIST OF ALL ALLERGIES/ALLERGIC
LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING
ARE YOU PREGNANT? TRYING TO GET PREGNANT? HORMONE THERAPY?
ARE YOU PRONE TO COLD SORES?

PERSONAL INFORMATION

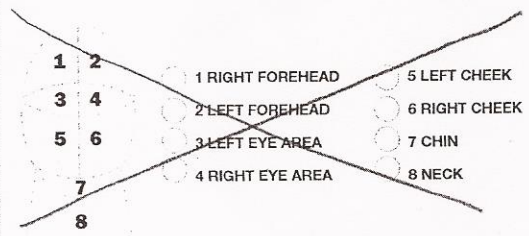
CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? DO YOU TAKE SUPPLEMENTS/VITAMINS?
DO YOU EXERCISE? IF SO, HOW OFTEN: YOUR LAST SUNBURN? DO YOU USE TANNING BEDS?
WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE CHECK ONE):
( ) ALWAYS BURN (I) ( ) USUALLY BURN (II) ( ) SOMETIMES BURN(III) ( ) RARELY BURN (IV) ( ) VERY RARELY BURN (V) ( ) NEVER BURN (VI)
HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:
( ) DERMATOLOGIST ( ) PLASTIC SURGEON ( ) ESTHETICIAN ( ) WOULD YOU BE INTERESTED IN COSMETIC SURGERY?
IF YES, WHAT PROCEDURE?

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)
( ) SUN SPOTS ( ) SKIN LAXITY ( ) DRY / ROUGH
WHAT SKIN LINE ARE YOU CURRENTLY USING?
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? IF NOT, WHY?
CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):
( ) NORMAL ( ) DRY/DEHYDRATED ( ) OILY ( ) ACNE/ACNE PRONE ( ) ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

REDUCTION OF FINE LINES
REDUCTION OF BROWN SPOTS/SUN DAMAGE
REDUCTION OF OIL/ACNE
ACNE SCARS DIMINISHED
REDUCTION OF REDNESS



TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

( ) ORMEDIC LIFT ( ) LIGHTENING LIFT ( ) ACNE LIFT ( ) IMAGE PERFECTION LIFT
( ) SIGNATURE LIFT ( ) WRINKLE LIFT ( ) ACNE ADVANCED LIFT ( ) TCA LIFT

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: DATE:

R-102708