CLIENT QUESTIONNAIRE - Microdermabrasion

Name: _____

MEDICAL INFORMATION:

NO	YES	
____	____	Accutane, If yes, when? _____
____	____	Allergies
____	____	Autoimmune disease, HIV, Lupus, Hepatitis
____	____	Eczema
____	____	Electrolysis
____	____	Glycolic Treatments, If yes, when? _____
____	____	Herpes, Cold Sores, Fever Blisters
____	____	Irregular, Pigmented Moles or Growths
____	____	Keloids, Pigmented Scars
____	____	Currently Pregnant, or Breast Feeding?
____	____	Retin A, Renova, If yes, when? _____
____	____	Sunburn
____	____	Warts
____	____	Waxing
____	____	Any condition not listed: _____
____	____	Currently under the care of a physician?
____	____	Currently taking any medication? _____
____	____	Previous laser procedures, chemical peel, dermabrasion or microdermabrasion, If yes, when? _____

In doing Microdermabrasion, my interest is primarily for (skin rejuvenation, acne, hyper pigmentation, scarring, etc.): _____

_____

Specific areas of concern: (eyes, mouth, forehead, etc.): _____

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