MICRODERMABRASION CLIENT CONSULTATION FORM

Name _____

Medical Information

____ Diabetes ___ Epilepsy ____Heart disease ____ Virus
____Pacemaker ____Hemophiliac ____ Pregnant ____Cortisone
____ Anticoagulants ____Hormonal treatments ____Circulatory
____Hypertension ____ I.D.U. ____Glandular
____Metallic implants

Skin disease:

_____

Are you pregnant or lactating? Yes No Are you prone to Herpes out brakes? Yes No

Please list all medications you take internally, include Accutane (and when last taken):

Please list any medications that you regularly use topically, include Retin-A, AHAs:

Please list any allergies or allergic reactions: _____

How much sun exposure do you receive? A lot Average Minimal

Do you suffer from any of the following problems?

Milia Comedones Acne-where? Rosacea Eczema Psoriasis

Age spots on hand Hyperpigmentation Hypopigmentation Moles

Broken capillaries Warts

Continued on back →

Have you ever experienced the following?

Professional facials Glycolic Peels Salicylic Peels Microdermabrasion

Jessner's Peels TCA Peels Medical dermabrasion Laser hair removal

Waxing-where? Brows, lips, legs, bikini area?

What do you hope to achieve from this treatment?

Signature: _____

Date: _____

Skin Examination
(For Esthetician Use only)

Skin Tone: Pink Olive Mediterranean Asian Black

Type of skin: Fine Normal Thick Normal

Secretions: Hypo Hyper Acne

Sup. Wrinkles: _____ Deep Wrinkles: _____
Skin abnormalities: _____
Scars: _____ Date: _____ Size: _____ Color: _____
Sensitivity: _____ Pigmentation spot: _____ Size: _____Color: _____

Professional Observation:
_____
_____