



Skin Care Patient Profile

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

Telephone: _____ Email: _____

Reason(s) you would like to see the esthetician: _____

Top skin concerns/issues: _____

Products you currently use on your skin: _____

Are you allergic to any product ingredients or medications? Yes ___ No ___ If so, what? _____

Have you ever had a chemical peel? Yes ___ No ___ If so, where? _____

Are you currently taking Accutane or have you ever taken Accutane? Yes ___ No ___

Do you currently use any topical Retinoid prescriptions (tretinoin/Retin-/isotretinoin/Accutane/Renova/Differin/Tazorac/Avage/EpiDuo/Ziana)? Yes ___ No ___ For how long? ___ What strength? _____

Have you ever had a bad reaction to skincare products? Yes ___ No ___ If so, Describe: _____

Do you consider your skin: Sensitive ___ Resilient ___ Unsure ___

Describe your skin (check all that apply):

Normal ___ Dry ___ T-Zone/Combination ___ Thick ___ Thin ___ Saggy ___ Firm ___ Oily ___ Acne ___
Blackheads ___ Milia ___ Rosacea ___ Eczema ___ Freckled ___ Sun-damaged ___ Melasma ___ Cysts ___
Occasional Breakouts ___ Large Pores ___ Hyperpigmentation ___ HypoPigmentation ___
Uneven texture ___ Sallow ___ Lacking Moisture ___ broken surface capillaries ___

What changes would you most like to see in your skin: _____

Patient Signature: _____ Date: _____