

Medical Esthetics Case History Card

NAME: _____ DOB: _____ AGE: _____ SEX: _____
ADDRESS: _____ PHONE: _____
CITY: _____ STATE: _____ ZIP: _____
E-MAIL: _____
HOW DID YOU HEAR ABOUT US? _____

1. Are you pregnant? Yes _____ No _____
2. Do you wear contact lenses? Yes _____ No _____ (Remove contacts if eyes are sensitive)
3. Do you currently have sunburn/wind burn/red face? Yes _____ No _____
4. Do you frequent tanning booths? Yes _____ No _____ (If within 3 weeks treatment not recommended.)
5. Do you currently get facial waxing/electrolysis/or use depilatories? Yes _____ No _____
(Wait 5 days between treatments)
6. Are you currently using *Biore* / snore strips? Yes _____ No _____
(Discontinue use 5 days before treatment)
7. Are you currently using Retin-A/Renova/Differin? Yes _____ No _____ What strength? _____
For how long? _____ How frequently? _____ Where applied? _____
(Discontinue use 5 days before treatment)
8. Are you currently using accutane? Yes _____ No _____ How Long? _____
9. Have you ever had a peel? Yes _____ No _____ Within the last 14 days? Yes _____ No _____
What kind? _____ Describe your reaction: _____
10. Have you recently had a facial surgery? Yes _____ No _____ Describe: _____
How long ago? _____
11. Have you recently had any laser treatments? Yes _____ No _____ When? _____
What kind? _____
12. Do you smoke? Yes _____ No _____ Develop cold sores/fever blisters? Yes _____ No _____ Last
breakout? _____
13. Are you affected by, or have any of the following: (please circle all that apply)
Skin diseases Herpes simplex Asthma Epilepsy Diabetes Cardiac problems Pacemaker

Metal pins or implants
14. Are you taking any medications at this time? (Antibiotics increase sensitivity) _____
15. Are you using glycolic/AHA home care products? Yes _____ No _____ If so, which one(s)? _____
How does your skin react to them? _____
16. What is your daily home care regimen? _____
17. What are the cosmetic improvements you would like to see in your skin? _____