COXHEALTH
med spa

Name _____ Birthdate _____ Date of Service _____

How did you hear about us? _____

What is your Occupation? _____

Aesthetician you are scheduled with today:

☐ Whitney Wade ☐ Amanda Woodman ☐ Sarah Goslee

What is your skin type? Select answer that best applies

☐ Normal ☐ Oily
☐ Dry ☐ Combination

Do you have reactive skin and/or a tendency to get red easy?

☐ Yes ☐ No

Have you had a facial before?

☐ Yes ☐ No

Do you have any topical allergies and/or allergies to aspirin?

☐ Yes If yes, what are they? _____
☐ No

Have you recently had any of the following? Please indicate how recently next to the service.

☐ Laser procedures ☐ Microneedling
☐ Cosmetic injections ☐ Removal of skin lesions by freeing
☐ Chemical peels ☐ Cosmetic Surgery
☐ IPL/BBL ☐ Other Cosmetic Procedures

Have you ever had an adverse reaction to a skincare service?

☐ Yes If yes, please specify: _____
☐ No

What skincare concerns would you like to address today? Please check all that apply (continues on next page)

☐ Dark spots ☐ Scarring
☐ Light spots ☐ Stretchmarks
☐ Wrinkles ☐ Veins
☐ Laxity ☐ Unwanted hair
☐ Redness ☐ Unwanted tattoos
☐ Acne ☐ Skincare products
☐ Other If other, please specify: _____

Have you ever been diagnosed with skin cancer or precancerous lesions?

☐ Yes If yes, please specify type and physician: _____
☐ No

Have you ever seen a physician regarding your skin?

- ☐ Yes If yes, please specify physician, when and what for: _____
- ☐ No

Do you currently or have you ever sunbathed and/or used tanning beds?

- ☐ Yes If yes, please most recent date and how often: _____
- ☐ No

Do you wear sunscreen daily?

- ☐ Yes If yes, what SPF and how often do you apply? _____
- ☐ No

Please list any medications you are currently taking or provide a list (please include supplements and vitamins)

_____

Have you used Isotretinoins (i.e. Accutane) within the last 6 months?

- ☐ Yes If yes, who is your prescribing physician?_____
- ☐ No

Do you use retinol or Retin-A?

- ☐ Yes If yes, how long since last use?_____
- ☐ No

Are you pregnant, nursing, or trying to become pregnant?

- ☐ Yes If yes, please specify: _____
- ☐ No

Have you ever smoked cigarettes?

- ☐ Yes If yes, when and for how long? _____
- ☐ No

Does your face ever feel dry and/or tight after cleansing?

- ☐ Yes
- ☐ No

Do you have any history of the following (please check all that apply) (continues on next page):

- ☐ Acne
- ☐ Keloid Scarring
- ☐ Blood Disorder
- ☐ Scleroderma
- ☐ Cardiac Abnormality
- ☐ Auto-Immune Disease
- ☐ Cancer
- ☐ Recent hormonal changes
- ☐ High blood pressure
- ☐ Dermatitis
- ☐ Psoriasis
- ☐ Eczema
- ☐ Fever Blister/Cold Sores
- ☐ Metal Implant(s)

Describe your current skincare regimen (Check all that apply and please specify):

- ☐ **Cleanser**
  - Brand _____
  - Product Name _____
- ☐ **Scrub**
  - Brand _____
  - Product Name _____
- ☐ **Toner**
  - Brand _____
  - Product Name _____
- ☐ **Serum(s)**
  - Brand _____
  - Product Name(s) _____
- ☐ **Retinol /** ☐ **Retinoid**
  - Brand _____
  - Percentage _____
- ☐ **Topical prescription(s)**
  - Product Name _____
- ☐ **Moisturizer(s)**
  - Brand_____
  - Product Name _____
- ☐ **Lip product(s)**
  - Brand _____
  - Product Name _____
- ☐ **Eye product(s)**
  - Brand_____
  - Product Name _____