

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):

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Auto-Immune | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Keloid Scarring | <input type="checkbox"/> Disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Recent hormonal | <input type="checkbox"/> Fever Blister/Cold |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> changes | <input type="checkbox"/> Sores |
| <input type="checkbox"/> Abnormality | <input type="checkbox"/> High blood | <input type="checkbox"/> Metal Implant(s) |
| | <input type="checkbox"/> pressure | |

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 _____

Product Name _____

Moisturizer(s)

Brand _____

Product Name _____

Lip product(s)

Brand _____

Product Name _____

Eye product(s)

Brand _____

Product Name _____

Topical prescription(s)