jenniffer & co.

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

DATE _____
NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
HOME PHONE _____
WORK PHONE _____
CELL _____
EMAIL _____
OCCUPATION _____
REFERRED BY _____

MEDICAL INFORMATION

DATE OF BIRTH _____ AGE _____ FAMILY PHYSICIAN _____
DO YOU SMOKE? _____ HOW OFTEN? _____ LIVING WITH A SMOKER? _____
HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)
◯ ACNE ◯ DEPRESSION ◯ SKIN DISEASE ◯ HIGH BLOOD PRESSURE
◯ COLDSORES ◯ DIABETES ◯ CANCER
LIST OF ALL ALLERGIES/ALLERGIC _____
LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING _____
ARE YOU PREGNANT? _____ TRYING TO GET PREGNANT? _____ HORMONE THERAPY?
ARE YOU PRONE TO COLD SORES? _____

PERSONAL INFORMATION

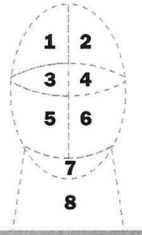
CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? _____ DO YOU TAKE SUPPLEMENTS/VITAMINS? _____
DO YOU EXERCISE? _____ IF SO, HOW OFTEN: _____ YOUR LAST SUNBURN? _____ DO YOU USE TANNING BEDS? _____
WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE CHECK ONE):
◯ ALWAYS BURN (I) ◯ USUALLY BURN (II) ◯ SOMETIMES BURN(III) ◯ RARELY BURN (IV) ◯ VERY RARELY BURN (V) ◯ NEVER BURN (VI)
HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:
◯ DERMATOLOGIST ◯ PLASTIC SURGEON ◯ ESTHETICIAN ◯ WOULD YOU BE INTERESTED IN COSMETIC SURGERY? _____
IF YES, WHAT PROCEDURE? _____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)
◯ SUN SPOTS ◯ SKIN LAXITY ◯ DRY / ROUGH
WHAT SKIN LINE ARE YOU CURRENTLY USING? _____
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? _____ IF NOT, WHY? _____
CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):
◯ NORMAL ◯ DRY/DEHYDRATED ◯ OILY ◯ ACNE/ACNE PRONE ◯ ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

_____ REDUCTION OF FINE LINES
_____ REDUCTION OF BROWN SPOTS/SUN DAMAGE
_____ REDUCTION OF OIL/ACNE
_____ ACNE SCARS DIMINISHED
_____ REDUCTION OF REDNESS



◯ 1 RIGHT FOREHEAD
◯ 2 LEFT FOREHEAD
◯ 3 LEFT EYE AREA
◯ 4 RIGHT EYE AREA
◯ 5 LEFT CHEEK
◯ 6 RIGHT CHEEK
◯ 7 CHIN
◯ 8 NECK

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

◯ ORMEDIC LIFT ◯ LIGHTENING LIFT ◯ ACNE LIFT ◯ IMAGE PERFECTION LIFT
◯ SIGNATURE LIFT ◯ WRINKLE LIFT ◯ ACNE ADVANCED LIFT ◯ TCA LIFT

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: _____ **DATE:** _____

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