NAME: _____ DOB:_____

Occupation:_____

Stress Level: 1 2 3 4 5 6 7 8 9 10

(1= no stress - 10 = lots of stress)

Do you participate in Sports?: YES NO

Type: _____

Cosmetic & Clinical History

Current feeling about your skin: _____

Reason for appointment today: _____

Previous skin care used (last 5 yrs):_____

Why no longer used: _____

Previous clinic services/frequency: _____

Were your expectations met previously:_____

Current Skin Care Products Used & Regime

TYPE	BRAND	SKIN TYPE LABELED FOR
Cleanser		
Toner		
Moisturizer		
Night cream		
Eye cream		
Exfoliants		
Masks		
Sun protection		
Makeup		

Nutritional Information

Food intolerance:_____

Food allergies: _____

Vitamin supplements: _____

_____

Fluid intake:

Water: _____ cups per day Coffee / tea: _____ cups per day

Alcohol: _____ glasses per week

Sun Exposure & Genetic History

Tanning ability: _____

MCIR Gene (redhead): _____

Maternal parental genetic history: _____

Tanning bed history: _____

Chronic Illness/conditions:_____

_____

Please circle any that apply

Diabetes / Type _____	Anemia	Blood pressure medication	
Cardiovascular medication	Hepatitis	Immune disorder	Smoker
Epilepsy / medication	Thyroid disorders	Keloid scarring	Vertigo

Additional information:_____

I agree that I will use the Dermavidual Products provided as instructed by office staff only. These products are specifically formulated for my personal use and are *non refundable* .

SIGNATURE : _____ **DATE:** _____

DERMANUVA
SKIN - LASER - HEALTH