

SILKPEEL PATIENT CONSULTATION FORM

Date _____

Personal Information

Name _____ Date of Birth _____

Medical Information

Primary Physician _____ Phone Number _____

Hair Color Blond Red Brown Light Brown Dark Brown Black Gray

Eye Color Brown Green Hazel Blue Black

Please list any health conditions you may have

Claustrophobic Diabetes Epilepsy Heart Disease High Blood Pressure

Low Blood Pressure Pacemaker Inflammation, irritation or skin infection Other _____

Are you pregnant or lactating? Yes No Are you prone to Herpes outbreaks? Yes No

Please list all medications you take internally and when taken last _____

Are you allergic to aspirin? Yes No Are you allergic to preservatives or dyes? Yes No

Please list any other allergies or allergic reactions _____

Please list all surgeries, including cosmetic _____

Life Style Information

Circle your level of stress (1 being low, 10 high) 1 2 3 4 5 6 7 8 9 10

Do you get 8 hours of sleep a night? _____ Do you salt your food? _____ How much milk do you drink daily? _____

Do you/did you smoke? _____ If yes, how many packs/day? _____ When did you stop smoking? _____

Do you exercise? _____ What is your intake of caffeine? _____ Are you a vegetarian? _____

How much water do you drink a day? _____ Do you eat peanut butter? _____ Do you eat a lot of fish? _____

How much alcohol do you drink a day? _____ Do you experience PMS? _____ Are you pre or post menopausal? _____

Do you take vitamin or mineral supplements? _____ What skin care products and cosmetics do you use? _____

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How much sun exposure do you receive? A lot Average Minimal

Do you suffer from any of the following problems?

- Whiteheads Age spot – hands Rosacea Warts Blackheads Hyperpigmentation Eczema
- Ingrown Hair Oily Complex Hypopigmentation Psoriasis Dry Scalp Acne – where? _____
- Moles Fine Lines Dehydration Broken Capillaries Wrinkles Cellulite

Have you ever experienced the following?

- Facial from an aesthetician Glycolic peels Endermologie Makeover Microdermabrasion Bodywraps
- Salicylic Peels Waxing Medical Dermabrasion Jessner’s peels Massage Laser Hair Removal
- Fillers / Botox TCA Peels Lash/Brow Tints

What do you hope to achieve from this consultation? _____

What are your goals for your future skin care program? _____

