SKINOVATION

SKINCARE & WAXING LLC

Name:
Address:
Phone:
Email:

Medical Information
List any medications, supplements that you are currently taking:
____

Do you have any specific skin care problems / allergies pertaining to your face or body?
____

What skin care products do you currently use?
____

Have you ever had chemical peel, laser, or any skin resurfacing treatments? If yes, when was your last treatment?
____
Do you use Retin A, Renova, or Adapalene?
____
Do you use acne medication? What kind?
____
Do you burn easily? _______
Do you use Glycolic Acid or AHA's ______
Do you experience breakouts? ______
What are your skin care goals?
____
Are you currently having your menstrual period? _______
Are you taking oral contraceptives or Antibiotics _______

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so.I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated.

Client Signature _________________________________ Date __________________