

### 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:

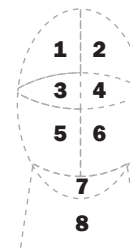
(BAD)    1    2    3    4    5    6    7    8    9    10    (FANTASTIC)

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      \_\_\_\_\_ ACNE SCARS DIMINISHED  
 \_\_\_\_ REDUCTION OF BROWN SPOTS/SUN DAMAGE      \_\_\_\_\_ REDUCTION OF REDNESS  
 \_\_\_\_ REDUCTION OF OIL/ACNE



- 1 RIGHT FOREHEAD       5 LEFT CHEEK  
 2 LEFT FOREHEAD       6 RIGHT CHEEK  
 3 LEFT EYE AREA       7 CHIN  
 4 RIGHT EYE AREA       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: \_\_\_\_\_